Tuscaloosa Integrative Family Medicine

Patient Information:

Name:____________________

DOB:__________ SS#:__________

Address: ____________________

City: __________ State: ____ Zip: ______

Home#: __________ Cell#: __________

E-mail: ______________ Sex: M / F

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Due to federal government requirements, please circle the following for patient being seen:

☐ Prefer not to answer

Race:	☐ Caucasian	☐ African American	
	☐ Pacific Islander	☐ Native American	
	☐ Alaskan	☐ Asian	☐ Other

Preferred Language: ☐English ☐Spanish ☐Other

Best Form of Contact:

☐ Home ☐ Cell

☐ Work ☐ Other:__________

Best time to call: __________

Ok to leave detailed message? Y / N

Preferred Pharmacy: This is pharmacy we will call your medications into unless you specify otherwise.

Pharmacy Name: __________

Pharmacy Phone #: __________

Guarantor Information:

(Person financially responsible for patient.)

☐Check here if same as above patient; if not please fill out.

Name: ____________________

DOB: __________ SS#: __________

Address: ____________________

City: __________ State: ____ Zip: ______

Home#: __________ Cell#: __________

E-mail: ______________ Sex: M / F

Relationship to patient: ☐Spouse ☐Child ☐Other

Insurance Information:

Primary: ____________________

Contract#: ____________________

Group#: ____________________

Subscriber Name: ____________________

Subscriber DOB: ____________________

Relationship to patient: ☐Spouse ☐Child ☐Self ☐Other

Secondary: ____________________

Contract#: ____________________

Group#: ____________________

Subscriber Name: ____________________

Subscriber DOB: ____________________

Relationship to patient: ☐Spouse ☐Child ☐Self ☐Other

Patient Employment:

Employer Name: ____________________

Work #: __________ Ext: ______

Emergency Contact:

Name: ____________________

Phone#: ____________________

Relationship: ____________________

How did you hear about us? (Mark all that apply)

☐Newspaper ☐TV ☐Phone Book ☐Internet

☐Spa ☐Friend/Relative ☐Doctor ☐Other:

____

Authorization for Release of Medical Records:

By providing this authorization I understand that the authorization is voluntary and is being done at the request of the patient. I understand that I may refuse to sign this authorization and my treatment and/or payment obligations will not be affected. I understand that the health information to be obtained and released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy Rules. I understand that I may revoke this authorization at any time by notifying Tuscaloosa Integrative Family Medicine in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. I understand that this authorization is for 6 years until otherwise specified.

I hereby authorize Tuscaloosa Integrative Family Medicine to use, disclose my health information as follows:

Name:__________ Relationship:______

Name:__________ Relationship:______

Name:__________ Relationship:______

Name:__________ Relationship:______

Assignment of Benefits & Guarantee of Account:

I acknowledge full financial responsibility for any charges incurred on my behalf as a patient, my family member who is a patient, or on behalf of the patient whom I have agreed to as responsible party. I understand that it is my responsibility as the patient to verify my contracted benefits with my insurance carrier in reference to any services provided by Tuscaloosa Integrative Family Medicine. I understand that all copays are due at the time of service. The portion which insurance does not cover is my financial responsibility. Tuscaloosa Integrative Family Medicine charges a fee of $30 for returned checks. In the event of a returned check, cash will be the only method of payment accepted for your account. In the event my account is turned over to a collection agency, I agree to pay all costs, including, but not limited to, collection fees and/or attorney's fees and all court costs, if any. I further agree to pay that outside agency an additional 30% on the outstanding portion of my account, hereby waive all rights of exemption under the Constitution and laws of the State of Alabama.

Signature: ____________________

<Patient signature if patient over age 13>

Signature: ____________________

<Guarantor if patient under age 13>

Today's Date: ____________________

Tuscaloosa Integrative Family Medicine

Health History Form

Name: ______________________________
DOB: ______/______/______

Why are you seeing the doctor today?

When did you first notice the symptoms?

Medical Problems:
Please list all medical problems/illnesses for which you are currently being treated:

Past Medical History:
Please indicate if you have had any of the following:

☐Mammogram ☐Colonoscopy ☐DEXA scan ☐Pneumonia Vaccine

Surgeries/Hospitalization	Year	Complications

Social History: Please check
☐ Employed (occupation) ______________
☐ Unemployed ☐ Disabled
☐ Work in home ☐ Student ☐ Retired
Children: ☐ Yes ☐ No Ages: ______________
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Exercise:
☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
What type of exercise: ______________
Are you on a special diet?
☐ Yes ☐ No Describe: ______________
History of substance abuse?
☐ Yes ☐ No Describe: ______________
Currently Smoke?
☐ Yes ☐ No Packs per day_____ for_____ years.
Previously a smoker?
☐ Yes ☐ No Quit for _____ years.
Drink Alcohol?
☐ Yes ☐ No Frequency:_______ Type: _______

Medication Example:		
Lexapro -- once daily	10 mg	2 years

Allergies: ☐ No Known Drug Allergies
Food/Environment: ______________
Medications: ______________

Family History:
Has anyone in your immediate family been diagnosed with the following disease? If yes, please indicate which family member.

Cancer	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Bleeding Disorders	☐ Yes	☐ No	

Review of Systems:
Are you currently having or have you had problems with:
If yes, please describe.

Allergic/Immunologic	☐ Yes	☐ No	
Cardiovascular (Heart)	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Ears, Nose, Throat	☐ Yes	☐ No	
Endocrine (Thyroid)	☐ Yes	☐ No	
Eyes	☐ Yes	☐ No	
Gastrointestinal	☐ Yes	☐ No	
Hematologic (Bleeding)	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Integumentary (Skin)	☐ Yes	☐ No	
Musculoskeletal	☐ Yes	☐ No	
Neurological	☐ Yes	☐ No	
Numbness/Tingling	☐ Yes	☐ No	
Psychiatric	☐ Yes	☐ No	
Psychological	☐ Yes	☐ No	
Respiratory (Lung)	☐ Yes	☐ No	
Urologic (Bladder)	☐ Yes	☐ No	

Patient Signature:

____

Date: ______/______/______

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