New Patient Information Form

Mr. Mrs. Miss Ms.: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Sex: M F Date of Birth: _____ Social Security #: _____

Marital Status: Single Married Divorced Widowed

Employer: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Spouse/Guarantor: _____ DOB: _____ Phone: _____

Address: _____ Soc Sec #: _____

City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

INSURANCE INFORMATION (please list subscriber if other than patient)

Primary: _____ Policy #: _____

Subscriber: _____ Group #: _____

Address: _____

Secondary: _____ Policy #: _____

Subscriber: _____ Group #: _____

Address: _____

Primary Care Physician: _____

Referred by: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance as indicated above and assign directly to BAHL & BAHL MEDICAL ASSOC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges wether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to BAHL & BAHL MEDICAL ASSOC for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or ectronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services.
Coinsurance and the deductible are based upon the charge determination of the Medicare Carrier

Insured Signature: _____ Date: _____

In Emergency, contact: _____ Phone: _____

Relationship: _____

Bahl & Bahl Medical Associates
PATIENT MEDICAL HISTORY

NAME: _____ DATE: _____

Please complete the following questionnaire as completely as possible.

1. MEDICAL HISTORY

Please list all current and prior health problems, including date of diagnosis (e.g. diabetes, high blood pressure, thyroid problems, heart conditions, depression, cancer, prior surgeries, etc.). Please place a star (*) by problems being currently treated by your doctors.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

2. ALLERGIES

Do you have allergies to medications? Please specify:

_____

_____

3. SOCIAL HISTORY

Marital status: Single Married Divorced Widowed

Occupation: _____

Tobacco use:

Do you smoke cigarettes? Yes No # of packs/day: _____

Do you smoke cigars or use smokeless tobacco? Yes No

Did you smoke in the past? Yes No # of packs/day:_____

When did you quit?_____ How many years did you smoke?_____

Alcohol use:

Do you drink? Yes No How often do you drink? _____

How much do you drink on those days? _____

Any street drug use? Yes No If yes, what type? _____ How often? _____

Have any events occurred recently that have caused you unusual amounts of stress?

_____

4. FAMILY HISTORY

If living, please list any health problems. If deceased, please list cause of death.

	Living	Deceased	
Mother	☐	☐	_____
Father	☐	☐	_____
Maternal Grandmother	☐	☐	_____
Maternal Grandfather	☐	☐	_____
Paternal Grandmother	☐	☐	_____
Paternal Grandfather	☐	☐	_____

Do you have any siblings? Yes No # brothers? ___ # sisters? ___

Do they have any health problems? If yes, please specify. _____

_____

Has anyone in your family been treated for any of the following?

	Yes	No	Relationship
Diabetes	☐	☐	_____
Thyroid disease	☐	☐	_____
Heart disease	☐	☐	_____
Stroke	☐	☐	_____
Cancer	☐	☐	_____
Genetic disorders	☐	☐	_____

Do you have any children? Yes No

List ages and health status of each child:

_____

_____

5. DIABETES HISTORY

Please skip this section if you do not have diabetes

How long have you had diabetes? _____
Last hemoglobin A1C: _____ date drawn? _____
What diabetes medications have you been on in the past? _____
_____

Date of last eye exam: _____ Any problems? _____
Do you see a podiatrist? Yes No If yes, date of last exam? _____
Do you have complications from your diabetes? Yes No
What complications do you have? _____

How often are you checking your blood sugars? _____
What are your average blood sugars? Fasting AM ____ lunch ____ dinner ____ bedtime ____
Any recent low blood sugar? Yes or No
If yes, last occurrence? _____ frequency of low blood sugar: _____

Do you follow a special diet? Specify: _____

Do you exercise regularly? Specify what kinds of exercise and how often: _____

_____

6. IMMUNIZATIONS

Have you had the following immunizations? If yes, please list the year/date you received the vaccine?

Influenza_____ Rubella_____

Pneumonia_____ Chicken Pox_____

Tetanus_____ Herpes Zoster_____

Diphtheria_____ Hepatitis A_____

Polio_____ Hepatitis B_____

7. Do you have a LIVING WILL and/or POWER OF ATTORNEY? Yes No

If yes, please list the name, address and telephone number of who holds these documents for you.

_____

8. PREVIOUS HOSPITALIZATIONS

List all hospitalization in the past 5 years, with the year and reason you were admitted. If you were admitted to the same hospital more than once, please list each admission separately.

Hospital	Address	Date	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. PHYSICIAN INFORMATION

- Please list the **names and complete addresses** of all physicians you have seen in the past 3 years, whom we may contact to obtain copies of your medical records.
- Place a check mark next to the physicians whom you would like a report of this evaluation sent.

	Physician	Address	Years Seen
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____
☐	_____	_____	_____

Review of Systems

Have you had any of these problems in the past month?

	Yes	No
<u>General</u>		
Fever or chills	____	____
Weight loss ____ #	____	____
Weight gain ____#	____	____
Fatigue	____	____
<u>Head, Ears, Eyes, Nose, Throat</u>		
Headaches	____	____
Blurred vision	____	____
Double vision	____	____
Hearing loss	____	____
Sinus problems	____	____
Dental problems	____	____
<u>Lungs and Heart</u>		
Shortness of breath	____	____
Frequent cough	____	____
Wheezing	____	____
Irregular heartbeat	____	____
Chest pain	____	____
Heart murmur	____	____
Swollen ankles	____	____
Leg cramps	____	____
<u>Gastrointestinal</u>		
Difficulty swallowing	____	____
Nausea or vomiting	____	____
Diarrhea	____	____
Constipation	____	____
Black or bloody bowel movements	____	____
Hemorrhoids	____	____
<u>Endocrine</u>		
Increased thirst	____	____
Increased urination	____	____
Increased appetite	____	____
Heat intolerance	____	____
Cold intolerance	____	____
Feeling nervous or irritable	____	____
Excessive sweating	____	____
Change in skin color	____	____
Neck pain	____	____
Neck swelling	____	____

	Yes	No
<u>Neurological</u>		
Numbness/tingling	____	____
Weakness of arms/legs	____	____
Pain radiating down legs	____	____
Dizziness	____	____
Fainting	____	____
<u>Musculoskeletal/Skin</u>		
Arthritis	____	____
Joint pain	____	____
Back pain	____	____
Swollen joints	____	____
Rashes	____	____
Ulcers/blisters	____	____
<u>Urologic</u>		
Painful urination	____	____
Blood in urine	____	____
Difficulty holding urine	____	____
Waking up to urinate at night	____	____
[for men only]		
Lump on penis	____	____
Lump on testicle	____	____
Discharge from penis	____	____
<u>Menstrual</u>		
Age periods began	____	
# days between periods	____	
# days periods last	____	
Severe cramping	____	____
Heavy flow	____	____
Irregular periods	____	____
Total numbers of:		
Pregnancies	____	
# live births	____	
# miscarriages/abortions	____	
# stillbirths	____	
Age at menopause	____	
Hysterectomy?	____	____
Ovaries removed?	____	____
Date of last pap smear:	____	
Date of last mammogram:	____	

Medication List

Please list all current medications with dose and frequency, or attach on a separate piece of paper.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____