ProHealth Partners Patient Information Sheet

PATIENT INFORMATION (*please print*)

First Name _____ Middle Initial _____ Last Name _____

Home Address _____ City _____ State _____ Zip Code _____

Billing Address (if different) _____

Work Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

Preferred Contact # _____ Email Address _____

Drivers License # _____ Date of Birth _____ Social Security # _____

Sex: __M __F Marital Status: □ S □ M □ D □ W □ Other _____ How did you hear about us? _____

Primary Care Physician _____ Primary Language _____

Race _____ Ethnicity (*circle one*) Hispanic or Latino Not Hispanic or Latino

Employer _____ Employer Phone _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone _____

GUARANTOR/PARENT/INSURED INFO [SEND BILL TO]:

Guardian Last Name (if applicable) _____ First _____ Initial ____

Date of Birth _____ Social Security # _____ Relationship _____

Employer _____ Address _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ Social Security # _____

Billing Address _____ City, State, Zip _____

Group or Policy # _____ Cert. or Member # _____ Local Union # _____

Co-pay Amount _____ Policy Effective Dates: From: _____ To: _____

Patient Relation to Policy Holder: □ Self □ Spouse □ Child □ Other: _____

PHARMACY INFORMATION

Pharmacy Name _____ Address _____ Phone _____

Signature (Patient or Parent of Minor): _____ Date: _____

over

Patient Name: _____ Account #: _____

Date: _____ DOB: _____

Please take the time to fill out the following form so that we can be sure your medical history is accurate and complete! Thank you.

Check only what applies. Print Only.

Past Medical History

- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Transfusions
- ☐ CAD
- ☐ Cancer
- ☐ Cardiac Pacer
- ☐ Cardiovascular Disease
- ☐ CHF
- ☐ Chicken Pox
- ☐ Cirrhosis
- ☐ Colitis
- ☐ COPD
- ☐ Chronic Renal Failure
- ☐ Crohn's disease
- ☐ CVA
- ☐ DVT
- ☐ Depression
- ☐ DM Type 1
- ☐ DM Type 2
- ☐ Epilepsy
- ☐ Fracture
- ☐ Gastric ulcer
- ☐ Gastrointestinal Disease
- ☐ Gastroesophageal Reflux Disease
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insulin Pump
- ☐ Joint Pain
- ☐ Kidney Disease
- ☐ Kidney Infections
- ☐ Kidney stone
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Progressive Neurological Disorder
- ☐ Pulmonary Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ STD
- ☐ Terminal Illness
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Tuberculosis
- ☐ Valvular Problems

Additional History:

Tobacco Assessment:

- □ Current every day smoker, Amount per day: _____
- □ Current some day smoker, Amount per day: _____
- □ Heavy tobacco smoker, Amount per day: _____
- □ Light tobacco smoker, Amount per day: _____
- □ Former smoker, Date Quit: _____
- □ Never smoker

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