ProHealth Medical Care

PATIENT INFORMATION (PLEASE PRINT AND COMPLETE ALL INFORMATION)

Last Name _____ First Name _____ Middle Name _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Date of Birth _____ Age _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow ☐ Separated Sex: ☐ M ☐ F

Patient's Place of Employment _____ Work Phone _____

Retired? ☐ Yes ☐ No

Person responsible for payment _____

Mailing Address of responsible party _____

How did you hear about us? ☐ Billboard ☐ Street Sign ☐ Website ☐ Print Ad *if so, where?* _____

☐ Employer ☐ Friend/Family ☐ Facebook ☐ Other _____

E-mail Address _____

May we email you monthly regarding ProHealth Medical Care coupons and specials? ☐ Yes ☐ No

FAMILY INFORMATION

Spouse's Name _____ Parent's Name (if patient is child) _____

Spouse's/Parent's Place of Employment _____ Work Phone _____

Please list the name of a relative or friend that we can reach in case of an emergency:

Name _____ Relationship _____ Phone _____

RELEASE OF INFORMATION

I authorize that I have reviewed a copy of the HIPAA (Health Insurance Portability and Accountability Act) and agree to the release of pertinent medical information to insurance carriers and other physicians for payment and treatment.

_____ _____ _____

Signature of Patient (or Patient's Representative, if patient is unable to sign or is a minor) Date Relationship

Patient's Name _____ Date _____

Patient History - Current or Recurring problems

Please check if you currently have or have had any of the following:

Genitourinary
- ☐ Frequency with urine
- ☐ Burning with urine
- ☐ Bloody urine
- ☐ Prostate problems
- ☐ Erectile dysfunction
- ☐ Kidney/Bladder problems

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep apnea

Cardiovascular
- ☐ Chest pain
- ☐ Ankle swelling
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Irregular heart beat
- ☐ Heart attack

Neurological
- ☐ Fainting
- ☐ Seizures
- ☐ Dizziness/Vertigo
- ☐ Headaches/Migraines
- ☐ Depression/Anxiety
- ☐ Psychiatric disorder

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Ulcers
- ☐ Heartburn

Musculoskeletal
- ☐ Joint pain / swelling
- ☐ Neck pain
- ☐ Back pain
- ☐ Gout
- ☐ Arthritis

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Osteoperosis

HEENT
- ☐ Hayfever / Allergies
- ☐ Vision problems

Other
- ☐ Anemia
- ☐ Cancer
- ☐ Hepatitis
- ☐ Liver problems
- ☐ Other: _____

Date of Last Preventative:

Colonoscopy: Year _____ Normal?: ☐ Y ☐ N
Pap: Year _____ Normal?: ☐ Y ☐ N
Mammograms: Year _____ Normal?: ☐ Y ☐ N
Bone Density: Year _____ Normal?: ☐ Y ☐ N
Physical: Year _____
Bloodwork: Year _____
PSA: Year _____
EKG: Year _____

Vaccines:

Tetanus: Year _____
TB: Year _____ Positive: ☐ Y ☐ N
Flu: Year _____
Pneumonia: Year _____

Past Surgical History

Description	*Date*

Family History:

Please check medical problems ***immediate family members*** have or have had in the past.

Medical Complaints	**Relationship**
☐ Diabetes	
☐ Hypertension (High blood pressure)	
☐ Cancer / Type: _____	
☐ High Cholesterol	
☐ Thyroid Disease	
☐ Heart Disease	

Medications:

List all current prescription and over-the-counter medications you are taking. Please include vitamins and herbal supplements.

Check if you are not taking medication. ☐

Name	Dose	Reason

Allergies:

List all food and medication allergies.
Check if you do not have any allergies. ☐

_____
_____
_____

Latex allergy? ☐ Y ☐ N

Social History

Do you smoke or use tobacco? ☐ Y ☐ N
If yes, how many packs/day? _____
Do you drink alcohol? ☐ Y ☐ N
If yes, how many drinks/week? _____
Do you use recreational drugs? ☐ Y ☐ N
Do you exercise? ☐ Y ☐ N
If yes, how many times/week? _____
Have you ever been a victim of violence? ☐ Y ☐ N
Have you had HIV or STD's? ☐ Y ☐ N

Females Only

Date of last menstrual period: _____
Current method of birth control: _____
Total # of pregnancies: _____
# of Live Births: _____
Miscarriages: _____
Abortions: _____

PATIENT AGREEMENT

Thank you for using ProHealth Medical Care.

By using ProHealth Medical Care services at reduced costs, please understand that you agree to the following regarding payment for services rendered.

1. Services are paid IN FULL at time of service by cash, check or charge card before leaving the clinic.

2. If you leave the clinic prior to paying for any visit, a $50.00 billing fee will be added to your charge and you will be billed accordingly.

3. We do not bill insurance companies, third-party payers or patients.

4. Additional fees associated with your office visit such as laboratory tests, procedures and/or injections, may be included and added to your office visit fee. If you have any questions, feel free to ask the clinic staff about any additional fees.

5. Financial costs in health care are a real concern for all of us and we understand the reality of limited financial resources. Additional testing that is offered by your provider, such as outside laboratory testing, x-rays, referral services, etc., should be communicated to you prior to ordering these tests. Additional testing should be your choice and you should always be in control of deciding if you want your provider to order any recommended tests.

6. We cannot control the charges levied by outside agencies, doctors, labs or consultants. Any additional services sent out to an independent agency may be billed separately by that agency if the fee is not collected at the time of service and will not be included in the price of your visit.

I have read and agree to the above terms.

Patient Name: _____
(Print)

Signed: _____ Date: _____
(If patient is a child, guardian's signature required)

CONSENT FORM

Name: _____ Date of Birth: _____ Age: _____ Sex: M F

CONSENT FOR TREATMENT: RELEASE OF MEDICAL INFORMATION & FINANCIAL RESPONSIBILITY

I, the undersigned, consent to treatment of the above named patient. I hereby authorize the release of any and/or all medical records to the referring physician, or those involved in the payment of the account. I further acknowledge full financial responsibility for any services rendered by ProHealth Medical Care, and understand that payment of charges incurred is due at the time of service.

Date: _____ Signed: _____

If patient is a child, guardian's signature is required

MEDICAL INFORMATION DISCLOSURE

I do hereby authorize that medical information about myself may be disclosed to the person or persons listed below. This includes current or past treatments, medication information, the discussion of any lab or x-ray results, consultation reports from any referring physicians, and in-patient information. I also authorize said person or persons to make payments on my behalf, to obtain prescriptions in my name in the event I am not present, and accept on my behalf any sample medication that might be offered as a courtesy to me. This designated person (or persons so named) may have the right to verify an appointment or make an appointment on my behalf. I do further absolve the staff of ProHealth Medical Care of any breach of confidentiality regarding my medical records and my privacy.

Release to: _____ Relationship: _____

Signed: _____ Date: _____

If patient is a child, guardian's signature is required

For Parents or Guardians of Minors only

IF THE PATIENT IS A DEPENDENT CHILD, THIS INFORMATION MUST BE PROVIDED

Guarantor: _____ Relationship: _____

Phone Home: _____ Work: _____ Cell: _____