Today's Date: ___________

PATIENT INFORMATION

Last Name: _________________________________ First Name: ______________________________ Middle Initial: ________

Previous Name: ____ Sex: ☐ Female ☐Male

Date of Birth: ______________________________Social Security Number: ____

Address: ____City: ______________________ State: _______ Zip:__________

Home Phone: _____________________ Cell Phone: _______________________ Work Phone: ___________________________

Email: ____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partner

Emergency Contact: ____ Relationship: ____________________________________

Home phone: _______________________________________ Cell Phone: ____

Employer: _____________________________Employer Phone: ____________________Occupation: _______________________

GUARANTOR INFORMATION

☒Same as patient

Relationship to you: ___________________________________ First and Last Name: ___________________________________

Date of Birth: ________________ Mailing Address: ____

City: _______________________________ State: _______ Zip: __________________ Phone Number: _____________________

INSURANCE INFORMATION

Primary Insurance: ___________________________________ ID: _________________________ Group: ___________________

Subscriber Name: ____________________________________ Subscriber DOB: _______________ Relationship: _____________

Subscriber Employer: _________________________________

Secondary Insurance: __________________________________ ID: _________________________ Group: ___________________

Subscriber Name: ____________________________________ Subscriber DOB: _______________ Relationship: _____________

Subscriber Employer: _________________________________

If Secondary insurance is Medicare, please fill out the Medicare Coordination of Benefits Questionnaire.

AUTHORIZATION TO BILL

I verify that this address, phone number, guarantor, and insurance is correct. I authorize my insurance benefits be paid directly to the health care provider. I am financially responsible for any balance due. I also authorize the health care provider or insurance company to release any information required for this claim. Medicare: I understand my provider agrees to accept the Medicare allowed charge as the full charge, and I am only responsible for the deductible, co-insurance, and non-coverage services.

Signature: ____ Date: ____________________

Print Name: ____ Date: ____________________

Patient or legally authorized individual signature. Signature required for FH to bill insurance.

ELECTRONIC COMMUNICATIONS

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☐Yes, I want to participate ☐No, I do not wish to participate at this time

Signature of patient or guardian: ____ Date: ____________________

Notice of Privacy Practices Acknowledgment

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Printed name of patient

Patient Signature or legally authorized individual Date Time

Printed Name (Signed on behalf of the patient) Relationship (Parent, legal guardian, personal representative)

Minor patient's signature, if applicable Date Time

FOR OFFICE USE ONLY

Office staff complete below:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: ____________________________ Staff member initials: ___________________

Reason(s):

____

____

FOUNDATION HEALTH

Patient Name: ____ DOB: ______________ Today's Date: ________________

Reason for visit: ____

Preferred Pharmacy: ____ Primary Care Provider: ___________________________

ALLERGIES

Medication Allergies and reactions: ____

Non-medication allergies: ____

MEDICATIONS

List all prescription and over the counter medications that you are currently taking regularly. Include vitamins, herbs, and other supplements and how you take them.

____
____
____
___

SOCIAL HISTORY

Do you smoke tobacco? ☐Current Smoker ☐Former Smoker ☐Never Smoked

Do you consume alcohol ☐ Yes ☐No Do you use any illicit drugs ☐Yes ☐No

SURGICAL HISTORY

Check if you have had: ☐Tonsillectomy ☐ Appendectomy ☐Gallbladder ☐Hysterectomy

List any other surgeries:

Type: ___________________________ Date: _____________ Type: ______________________________ Date: ______________

Type: ___________________________ Date: _____________ Type: ______________________________ Date: ______________

FOR FEMALES ONLY

Date of last period: ______________ Date of last Pap smear: ______________ ☐Normal ☐Abnormal

Date of last mammogram: __________ ☐Normal ☐Abnormal Date of last colonoscopy: _____________ ☐Normal ☐Abnormal

If post-menopausal, are at menopause: _____________ Are you sexually active? ☐Yes ☐No

If yes, what is your current birth control method: _________________________________

Number of pregnancies: _____ Full term: ______ Premature: _____ Abortion: _____ Miscarriage: ______ Living children: ________

PAST MEDICAL HISTORY Check if you have had:

☐Anemia	☐Eczema	☐Migraine Headaches
☐Asthma	☐Hay Fever	☐Pneumonia
☐Bladder Infections	☐Head Injuries	☐Polio
☐Blood Clots	☐Hives	☐Rheumatic Fever
☐Broken Bones	☐Jaundice	☐Seizure or Epilepsy
☐Cancer:	☐Joint Dislocation	☐Sexually Transmitted Diseases
☐Colitis or Other Bowl Disease	☐Kidney Disease	☐Stomach Ulcer or Reflux
☐Depression	☐Liver Disease	☐Stroke
☐Diabetes	☐Meningitis	☐ Thyroid Problems
☐Drug or Alcohol Problems	☐Mental Disorder	

REVIEW OF SYSTEMS

Check any/all of the following symptoms that are you **CURRENTLY** concerned about:

GENERAL HEALTH	**CARDIOVASCULAR**	**GENITAL/URINARY**	**NEUROLOGY**
☐No complaints	☐No complaints	☐No complaints	☐No complaints
☐Fever	☐Chest pain	☐Blood in urine	☐Numbness
☐Chills	☐Rapid heart rate	☐Painful urination	☐Weakness
☐Sweats	☐Lightheadedness	☐Frequency	☐Tingling
☐Loss of appetite	☐Passing out/fainting	☐Urgency	☐Burning
☐Fatigue	☐Shortness of breath	☐Incontinence	☐Shooting pain
☐Weight gain	☐Swelling in feet/ankles	☐Vaginal/Penile discharge	☐Headache
☐Weight loss	☐Leg pain with exercise	☐Abnormal periods	☐Dizziness
☐Fussy	☐Heart palpitations	☐Bedwetting	☐Loss of concentration
☐Diminished activity		☐Genital lesion	☐Seizure
	BREAST	☐Urinary hesitancy	☐Tremors
EYE	☐No complaints	☐Pelvic pain	☐Difficulty with balance
☐No Complaints	☐Pain		☐Difficulty speaking
☐Blurry vision	☐Redness	**MUSCULOSKELETAL**	☐Difficulty swallowing
☐Double vision	☐Tenderness	☐No complaints	☐Clumsiness
☐Irritation/itching	☐Nipple discharge	☐Joint swelling	☐Confusion
☐Redness	☐Enlargement	☐Neck pain	☐Memory loss
☐Discharge	☐Lump: L or R	☐Upper back pain	
☐Vision loss		☐Lower back pain	**PSYCIATRIC**
☐Eye pain	**RESPIRATORY**	☐Joint pain	☐No complaints
☐Sensitivity to light	☐No complaints	☐Joint stiffness	☐Depression/Anxiety
	☐Coughing	☐Muscle weakness	☐Suicidal thoughts
Ear/Nose/Throat	☐Wheezing		☐Insomnia
☐No complaints	☐Chest tightness	**SKIN**	☐Stress
☐Ear pain	☐Painful breathing	☐No complaints	☐Loss of interest
☐Ear discharge	☐Rapid breathing	☐Itchiness	☐Excessive sleep
☐Ear ringing/buzzing	☐Difficulty breathing	☐Dry skin	☐Fear
☐Loss of hearing	☐Coughing up blood	☐Redness	
☐Nasal congestion	☐Coughing up phlegm	☐Rash	**ENDOCRINE**
☐Sinus pressure		☐Diaper rash	☐No complaints
☐Drooling	**GASTROINTESTONAL**	☐Hives	☐Gets cold easily
☐Facial swelling	☐No complaints	☐Skin lesion	☐Overheats easily
☐Sore throat	☐Difficulty swallowing	☐Skin growth	☐Increased thirst

Perpetual Authorization to Share Protected Health Information (PHI) allows our office to discuss your healthcare information with the person(s) you list below.

Patient Name: ____

Date of Birth: ________________________ Previous Name: ____

I authorize Foundation Health to leave ***detailed messages*** for the above-named patient on the phone number(s) listed here:

☐ Yes ☐ No

I authorize Foundation Health (including all clinics, offices, and ancillary services) to share limited protected health information about my condition and care with the individual(s) listed below, who are involved in my ongoing care.

____

Name Phone Number Relationship

____

Name Phone Number Relationship

____

Name Phone Number Relationship

You may include information specific to the following (check all that apply)

☐HIV (AIDS virus) ☐Drug and/or alcohol use
☐Mental health or illness ☐Reproductive healthcare – only for minors under 18 yrs of age
☐Sexually Transmitted diseases

Minors: a minor patient's signature is required to disclose information related to reproductive care (at any age), sexually transmitted disease (age 14+), HIV/AIDS (age 14+), drug/alcohol abuse (age 13+), and mental health or illness (age 13+).

Note: This form is valid until cancelled by the patient or legally authorized individual, or when a minor patient turns 18. **This form does not authorize release of any medical records**

____

Patient or legally authorized individual signature Date

____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, etc.)

____

Minor patient's signature, if applicable Date

FOUNDATION HEALTH

Today's Date: ___________

PATIENT INFORMATION

Last Name: _________________________________ First Name: ______________________________ Middle Initial: ________

Previous Name: ____ Sex: ☐ Female ☐Male

Date of Birth: ______________________________Social Security Number: ____

Address: ____City: ______________________ State: _______ Zip:__________

Home Phone: _____________________ Cell Phone: _______________________ Work Phone: ___________________________

Email: ____

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed ☐Partner

Emergency Contact: ____ Relationship: ____________________________________

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Subscriber Name: ____________________________________ Subscriber DOB: _______________ Relationship: _____________

Subscriber Employer: _________________________________

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Reason(s):

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