

POTOMAC PRIMARY CARE

Patient Information

Date: _____

Email: _____

Permission to contact via Email Yes No

First Name: _____ M.I. _____ Last Name: _____

Address: _____ Apt/Unit# _____

City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____

Date of Birth: ____/____/____ SS# _____

Primary Care Physician: _____ Number: (____) _____

Pharmacy: _____ Number: (____) _____

Emergency Contact

Name: _____ Relationship: _____ Emergency Phone Number (____) _____

Guarantor Information

(Responsible Party Information)

First Name: _____ M.I. _____ Last Name: _____

Address: _____ Apt/Unit# _____

City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____

Primary Insurance Information

(Please provide your insurance card to receptionist to copy)

Effective Date: _____ Insurance Name: _____

Insurance Claims Address: _____

Address: _____ Apt/Unit# _____

City: _____ State: _____ Zip Code: _____ Phone Number: (____) _____

Group# _____ Insurance ID or Policy #: _____ Copay: _____

Policyholder's Name: _____ Policyholder's Relationship to Patient: _____

Address: _____ Apt/Unit# _____

City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____

Policyholder's Date of Birth: _____ Sex: Male Female Social Security # _____

Policyholder's Employer: _____ Work Phone: (____) _____

Secondary Insurance Information

Effective Date: _____ Insurance Name: _____

Insurance Claims Address: _____

Address: _____ Apt/Unit# _____

City: _____ State: _____ Zip Code: _____ Phone Number: (____) _____

Group# _____ Insurance ID or Policy #: _____ Copay: _____

Policyholder's Name: _____ Policyholder's Relationship to Patient: _____

Address: _____ Apt/Unit# _____

City: _____ State: _____ Zip Code: _____ Home Phone: (____) _____

Policyholder's Date of Birth: _____ Sex: Male Female Social Security # _____

Policyholder's Employer: _____ Work Phone: (____) _____

Accident Information (If applicable)

Date of Accident: _____ Circle One: Auto Related Work Related Sports Related Other

Insurance Claim #(if known) _____ Claim Adjustor Name _____

HOW DID YOU LEARN ABOUT US?

Referring Provider Website HealthGrades.com

Other _____

Family/Friends Blog Vitals.com

Search Engine Facebook Yelp.com

Physician Directory Twitter Google Places Page

How Can We Reach You?

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

Name (Please Print): _____

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____

HealthOne Clinic Services
Phone Message Consent

In effort to protect your privacy, we have developed a policy on leaving medical care messages:

- We will **NOT** leave messages with anyone except the patient or legal guardian.
- We will **NOT** leave any confidential information on an answering machine.
- We will **NOT** leave any message on voicemail.

Unless
WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your medical care.

I, _____ give HealthOne my permission to speak with and/or leave phone messages regarding my meical care and/or billing concerns/questions with the following. I fully understand that this consent will remain valid until revoked in writing.

My home answering machine: Initials _____

My work voice mail: Initials _____

My celluar voice mail: Initials _____

My spouse/guardian: Initials _____

Other: _____ Phone Number: _____ Initials _____

EMERGENCY CONTACT:

Name: _____ Phone Number: _____

Initials _____

Signature: _____

Date: _____

PATIENT HEALTH HISTORY

Date: _____

Name: _____

D.O.B.: _____

REASON FOR TODAY'S VISIT:

CURRENT PRESCRIPTION MEDICATIONS:

OVER THE COUNTER MEDICATIONS AND SUPPLIMENTS:

CURRENT MEDICAL PROBLEMS:

MEDICAL HISTORY:

SURGICAL HISTORY:

ALLERGIES:

HAVE YOU EVER BEEN TOLD YOU'VE BEEN TREATED FOR ANY OF THE FOLLOWING?

- High Cholesterol
- High Triglycerides
- High Blood Sugar
- Abnormal Liver Tests
- Abnormal Kidney Tests
- Atherosclerosis
- Heart Disease
- Cancer
- Asthma
- Depression/Anxiety
- Thyroid Disease
- Other _____

FAMILY HISTORY: Have your parents, siblings, or grandparents had any of the following:

- Colon Cancer
- Breast Cancer
- Prostate Cancer
- Other Cancer: _____

- Heart Attack
- Diabetes
- Other Heart Disease: _____

- Other: _____

Has a family member died less than 50 years of age?

TELL US HOW YOU'RE DOING

Have you had any of the following symptoms on a frequent or recurring basis in the last few months?

- YES NO Unexplained weight loss or weight gain
- YES NO Fever or chills
- YES NO Headaches
- YES NO Dizziness or lightheadedness
- YES NO Blurred or double vision
- YES NO Red or itchy eyes
- YES NO Ear Aches, sore throat, runny nose or nasal congestion
- YES NO Palpations or Irregular heart beat
- YES NO Chest Pain
- YES NO Cough, shortness of breath, wheezing
- YES NO Heartburn
- YES NO Nausea or vomiting
- YES NO Constipation, diarrhea or rectal bleeding
- YES NO Urinary frequency or burning with urination
- YES NO Rash
- YES NO Depression or anxiety
- YES NO Frequent infections
- YES NO Back Pain or Joint Pain
- YES NO Bruising or Bleeding

When was your last (Please provide dates):

Normal

Abnormal

Pap Smear _____

Mammogram _____

Colonoscopy _____

Prostate Check Up _____

Dental Visit _____

Eye Exam _____

Do you eat a healthy diet? _____

How many times per week do you exercise?

Do you practice safe sex? _____

What is your sexual preference? _____

Are your immunizations up to date? FLU PNEUMONIA TETANUS SHINGLES

Do you smoke or chew? No Yes, if so how much per day?

Other Drugs? No Yes, if so how much per day?

Alcohol Intake: No Yes

Have you had more than 5 drinks in a day in the past 6 months? Yes ___ No ___

Have you been hospitalized for Mental/Emotional Reasons?

Have you been under more stress than usual lately?

