

PATIENT INFORMATION

First Name: _____ Middle Initial: _____
Last Name: _____ Date of Birth: _____
Social Security Number: _____ Gender: Male Female
Native/Preferred Language: _____ Home Number: _____
Communication Needs: Hearing Vision Cognitive Cell Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Marital Status: _____ Employment/Student Status: _____
Family Doctor: _____ Referring Doctor: _____
Pharmacy Preference: _____ Occupation: _____
Employer/School: _____ Work Number: _____
Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to answer
Race: African American American Indian/Alaska Asian Caucasian
 Hispanic or Latino Native Hawaiian/Pacific Islander Decline to answer
Email: _____ Decline e-mail Decline texts

By providing your cell phone number and/or e-mail address, you allow Medical Associates of Erie to send personal information to you via e-mail/text. We can also use e-mail/text for appointment confirmation. If you prefer that we do not contact via text or e-mail, please mark decline. Standard data messaging rates will apply for text confirmations

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Primary Caregiver: _____

Phone Number: _____ Relationship: _____

Legal Guardian: _____

Phone Number: _____ Relationship: _____

The following have been completed (please provide a copy of any documents for your medical record):

Advance Directive for Health Care Living Will Physician Orders for Life Sustaining Treatment

Healthcare Proxy: _____

Phone Number: _____ Relationship: _____

Account Information: Is the above referenced patient over the age of 18? Yes No

If yes, the patient is legally responsible for all financial obligations to this office.

If No, who is financially responsible for this account? _____

Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____ Work Number: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____ Relationship to Patient: _____

Insurance information: Please provide your insurance card(s) to the receptionist. This will be scanned into our system to enable us to submit claims to your insurance company on your behalf.

If the patient is not the policy holder for their primary, secondary or tertiary insurance please list the subscriber's information below:

Primary Insurance Company: _____ Effective Date: _____

SUBSCRIBER Information for this Policy

Last Name: _____ Home Number: _____

First Name: _____ MI: _____ Cell Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Relationship to Patient:

ID or Policy #: _____ Self Spouse

Group #: _____ Child Other

Name of Employer: _____

Secondary Insurance Company: _____ Effective Date: _____

SUBSCRIBER Information for this Policy

Last Name: _____ Home Number: _____

First Name: _____ MI: _____ Cell Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Relationship to Patient:

ID or Policy #: _____ Self Spouse

Group #: _____ Child Other

Name of Employer: _____

Tertiary Insurance Company: _____ Effective Date: _____

SUBSCRIBER Information for this Policy

Last Name: _____ Home Number: _____

First Name: _____ MI: _____ Cell Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Relationship to Patient:

ID or Policy #: _____ Self Spouse

Group #: _____ Child Other

Name of Employer: _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS, AND REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS OR PARTICIPATES.

SIGNED: _____ Date: _____

I UNDERSTAND THE PROVIDER'S CHARGES MAY EXCEED THE INSURANCE PAYMENTS, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT. SHOULD MY ACCOUNT EVER BECOME DELINQUENT AND ELIGIBLE FOR COLLECTION, I UNDERSTAND AN APPROPRIATE COLLECTION FEE WILL BE ASSESSED.

SIGNED: _____ Date: _____

Please describe/explain the reason for today's appointment: _____

REVIEW OF SYSTEMS: Please check all that apply.

Constitutional

- Chills
 Decline in Health
 Fatigue
 Fever
 Weakness
 Weight Gain
 Weight Loss

Head

- Dizziness
 Fainting
 Head Injury
 Headaches
 Pain

Eyes

- Blurry Vision
 Cataracts
 Discharge
 Double Vision
 Excessive Tearing
 Eyeglass/Contact Use
 Eye Pain
 Glaucoma
 Infections
 Pain with Light
 Recent Injury
 Redness
 Vision Loss
 Unusual Sensations

Nose

- Discharge
 Frequent Colds
 Infections
 Nasal Obstruction
 Nosebleeds
 Runny Nose
 Sinus Infections

Mouth

- Bleeding Gums
 Change in Dentition
 Hoarseness
 Postnasal Drip
 Tongue Burning
 Voice Changes

Ears

- Discharge
 Hearing Aid
 Hearing Impairment
 Infections
 Pain
 Ringing in Ears

Throat & Neck

- Enlarged Tonsils
 Frequent Sore Throats
 Lumps
 Tenderness

Respiratory

- Bringing up Sputum
 Cough
 Coughing Blood
 Pain with Breathing
 Wheezing
 Wheezing w/ Exertion

Cardiovascular

- Chest Pain
 Extremity(s) Cool
 Extremity(s) Discolored
 Heart Murmur
 High Blood Pressure
 Palpitations
 Short of Breath
 Short of Breath w/ Exertion
 Swelling of Legs or Feet
 Varicose Veins

Gastrointestinal

- Abdominal Pain
 Black Tarry Stools
 Change in Appetite
 Change in Stools
 Constipation
 Diarrhea
 Heartburn
 Hemorrhoids
 Nausea
 Rectal Bleeding
 Rectal Pain
 Trouble Swallowing
 Vomiting
 Vomiting Blood

Musculoskeletal

- Arthritis
 Back Problems
 Gout
 Joint Pain
 Joint Stiffness
 Muscle Cramps
 Muscle Stiffness
 Paralysis
 Restricted Motion
 Tremors
 Unsteady Gait

Psychiatric

- Behavioral Changes
 Depression
 Disorientation
 Disturbing Thoughts
 Excessive Stress
 Hallucinations
 Memory Loss
 Mood Changes
 Nervousness

Breasts

- Discharge
 Lumps
 Pain
 Tenderness

Skin

- Bruising
 Dryness
 Eczema
 Hair Texture Changes
 Hives
 Itching
 Loss of Hair
 Lumps
 Mole Increased Size
 Nail Growth Changes
 Nail Texture Changes
 Pitting Nails
 Rash
 Skin Color Change
 Ulcer or Wound

Neurological

- Blackouts
 Loss of Consciousness
 Numbness
 Seizures
 Tingling or Burning

Endocrine

- Cold Intolerance
 Excessive Urination
 Goiter
 Heat Intolerance
 Hot Flashes
 Increased Thirst
 Sweats

Hematologic/Lymph

- Anemia
 Bleeds Easily
 Blood Clots
 Easy Bruisability
 Enlarged Lymph Nodes
 Low Blood Cell Counts

Allergic/Immunologic

- Itchy Eyes
 Seasonal Allergies
 Sneezing
 Watery Eyes

Urinary

- Awakening to Urinate
 Blood in Urine
 Burning or Pain w/ Urination
 Difficulty Starting Stream
 Flank Pain
 Frequency
 Incontinence
 Retention
 Urgency
 Urine Discoloration or Odor

Genitals Male Female

- Discharge
 Irregular Menstruation
 Itching
 Lesions
 Pain
 Sexual Problems
 Venereal Disease

PAST MEDICAL HISTORY: Please list any past medical conditions with pertinent details including recent hospitalizations and/or ER visits.

SOCIAL HISTORY: Please check the appropriate option.

Do you Smoke? Yes No Have you ever Smoked? Yes No
Packs per Day: _____ Do you use any other tobacco products? Yes No
Number of Years: _____ Please Specify: _____
Do you Drink Alcohol? Yes No Type: Beer Wine Liquor Drinks per Week: _____
Do you Drink Caffeine? Yes No Drinks per Week: _____
Do you use Recreational Drugs? Yes No
Please Specify: _____ Last Used: _____

MISC SOCIAL HISTORY: Please check the appropriate option.

Military Service? Yes No Branch: _____ When did you serve? _____
Location of Service: _____
Do you live alone? Yes No Members of you Household: _____
Education: Some College Some High School High School Graduate GED
Vocational School College Graduate Post Graduate Degree
Have you recently lived or traveled to a foreign country? Yes No Where: _____
Have you had any exposure to TB (tuberculosis)? Yes No When: _____
Have you had any environmental exposure such as asbestos, coal inhalation or second hand smoke?
Yes No Please Specify: _____
Do you have any pets? Yes No Please Specify: _____
Do you have any known risk factors for HIV/AIDS? Yes No
Hobbies/
Interests: Arts & Crafts Camping Cars Computers Dancing Fishing
Gardening Hiking Hunting Motorcycle or Bike Riding Music
Reading Spectator Sports Other: _____

SURGICAL HISTORY: Please list any procedure or surgery that you have had and include any abnormal findings or complications. **No Surgical History**

OBSTETRIC HISTORY: For Women Only.

Total Pregnancies	Full Term	Premature	Abortions	Miscarriages	Ectopics	Multiple Births	Living

HEALTH MAINTENANCE: Please note any details regarding screenings or other physician visits you have had.

Test	Date	Office/Physician	Result
Bone Density (DEXA)			
Colonoscopy			
Dental Exam			
Eye Exam			
Flu Shot			
Hemoglobin A1C			
Hepatitis C Screening			
Hepatitis Vaccine			
Mammogram			
Pap Smear			
Pevnar 13			
Pneumovax 23			
Shingles Vaccine			
Tetanus Vaccine			
Other			
Other			

Name of Person Completing Form: _____
 Relationship to Patient: _____