LECOM HEALTH
MEDICAL ASSOCIATES OF ERIE

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
☐Decline e-mail

Email: _____

By providing your e-mail address, you allow Medical Associates of Erie to send personal information to you via e-mail. We can also use e-mail for appointment confirmation. If you prefer that we do not contact via e-mail, please mark decline.

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: _____

 Patient Name: _____ Date of Birth: _____

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 ELIGBLE FOR COLLECTION, I UNDERSTAND AN APPROPRIATE COLLECTION FEE WILL BE ASSESSED.

SIGNED: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices (HIPAA)

By signing below, I acknowledge that I have received and understand or refused a copy of this office's *Notice of Privacy Practices* Form which contains a description of the uses and disclosures of my health information. I further understand that this office may update its Notice of Privacy Practices at any time and that I may receive an updated copy by submitting a request in writing for a current copy of this office's Notice of Privacy Practices Form.

_____
Print Patient's Name

_____ _____
Signature of Patient Date

If completed by patient's personal representative, please print name and sign below.

_____ _____
Print Patient's Personal Representative Name Relationship to Patient

_____ _____
Signature of Patient's Personal Representative Date

Staff to complete if unable to obtain signature of patient and patient's personal representative.

Office staff made a good faith effort to obtain written acknowledgement from the patient and patient's personal representative of the *Notice of Privacy Practices*, but was unable to do so for the reasons documented below:

☐ Patient and patient's personal representative refused to sign
☐ Patient and patient's personal representative unable to sign
☐ Other: _____

_____
Print Employee Name

_____ _____
Signature of Employee Date

Release of Information Authorization

I hereby authorize Medical Associates of Erie or any agent to release the following medical information:

☐ Test Results ☐ Consultant/Procedure Results ☐ Answers to Medical Questions

The above items may be released to the following person(s):

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

 Patient Name: _____ Date of Birth: _____

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

 Patient Name: _____ Date of Birth: _____

Allergies or Intolerance to Medications or Food (include type of reaction): ☐ **No Known Allergies**

MEDICATIONS: Please list (or attach a copy) all prescription and non-prescription medications, vitamins, home remedies, birth control, herbs, inhalers, etc. ☐ **I am not currently taking any medications.**

Name of Medication	**Dosage (e.g. mg/pill)**	**Times per Day**

☐ **Medication List Attached** ☐ **Additional Medications Listed on Back of Form**

CONSENT FOR MEDICATION HISTORY REVIEW: I authorize Medical Associates of Erie to obtain an electronic record of my medication history to aid in the complete documentation within my medical record.

Patient Signature: _____

FAMILY HISTORY: Please note below any history of medical problems in the family. Please include details such as relationship of family member and if they are alive or deceased.

Were you adopted? ☐Yes ☐No ☐ **Family History Unknown**

 Patient Name: _____ Date of Birth: _____

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: _____

 Patient Name: _____ Date of Birth: _____

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			
Prevnar 13			
Pneumovax 23			
Shingles Vaccine			
Tetanus Vaccine			
Other			
Other			

Name of Person Completing Form: _____

Relationship to Patient: _____