Your Doctor's Office, PC

8630 Vaughn Rd Montgomery, Al. 36117 334-676-4076

Patient Information Record

If patient is 18 or under, parent or legal guardian must complete this section.

Father's name: _____ Date of Birth: _____ Phone # _____

Address: _____

Mother's name: _____ Date of Birth: _____ Phone # _____

Address: _____

Patient name: _____ DOB: _____ Acct# _____

Address: _____ **SSN#** _____

City: _____ State: _____ Zip Code: _____

Phone #: Cell _____ Home _____ Work _____ Employed: Yes _____ No: _____

Marital Status: M_____ S _____ D _____ W _____ Sex: M_____ F _____

Emergency Contact:

Name: _____ Phone # _____

Address: _____

Relationship:

Spouse: _____ Friend: _____ Relative: _____

Pharmacy: _____ Phone # _____

Insurance:

Primary Insurance: _____ Contract #: _____ Group #: _____

Secondary Insurance: _____ Contract #: _____ Group #: _____

Patient Agreement, Assignment of benefits, Release of Records, and Authorization of Treatment

I, the undersigned, promise to pay, in full, to Your Doctor's Office, PC for all charges in consideration of work done and materials furnished immediately upon such charges being incurred. Upon default, I agree to pay any rebilling charges, interest rates, reasonable legal fees, all costs associated with the collection of this note. I further understand that if payment becomes 90 days past due, I will also be responsible for a delinquency charge at the maximum allowable rate from the date the payment was due.

I hereby authorize assignment of benefits to Your Doctor's Office, PC for any medical services rendered by them. I also authorize release of my medical records and any documentation necessary to obtain reimbursement for services.
If I am referred to another provider, I authorize Your Doctor's Office, PC to forward my medical record as it relates to such referral to the provider. Additionally, upon my verbal request for a copy of my record and repayment for such copies, this shall serve as sufficient authorization. A copy shall be as valid as the original.

Signature of Patient (Parent or Guarantor): _____ Date: _____

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Patient Name: _____ DOB: _____ Account Number: _____

I give Your Doctor's Office, PC, permission to discuss protected health information and release diagnostic test results to the following person(s):

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Please initial each item below to indicate your understanding

_____ I understand the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been release in response to the authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

_____ _____

Signature or Patient/Parent **Date**

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself, please sign below.

_____ _____

Signature or Patient/Parent **Date**

The above information is private and confidential and will be placed in your medical file. The information on this form will remain valid until we are notified otherwise.

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Patient Personal History Form

Please take time to update the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.

Name: _____ **Birthdate:** _____ **Date:** _____

Chief Complaints (Please list current symptoms)

1. _____ 3. _____
2. _____ 4. _____

Past Medical History: Hospitalizations and surgeries

Reason/Diagnosis/Procedure	Date	Reason/Diagnosis/Procedure	Date
1.		4.	
2.		5.	
3.		6.	

Medical Illnesses or conditions: (Conditions you now have or have had in the past.)

Condition	Onset	Condition	Onset	Condition	Onset
□ Migraine headaches	_____	□ Stomach or duodenal ulcer	_____	□ Goiter	_____
□ Seizures or convulsions	_____	□ Hepatitis	_____	□ Gonorrhea	_____
□ Stroke	_____	□ Cirrhosis	_____	□ Syphilis or VD	_____
□ Polio	_____	□ Gall stones	_____	□ HIV infection	_____
□ Glaucoma	_____	□ Colon or bowl trouble	_____	□ Herpes infection	_____
□ Cataracts	_____	□ Dysentery or serious diarrhea	_____	□ Chicken pox	_____
□ Blindness	_____	□ Rectal trouble	_____	□ Mumps	_____
□ Recurrent ear infections	_____	□ Hemorrhoids	_____	□ Measles	_____
□ Deafness	_____	□ Recurrent urinary infections	_____	□ Recurrent boils	_____
□ Hay fever, allergic nose	_____	□ Kidney stones	_____	□ Skin problems	_____
□ Recurrent sinusitis	_____	□ Other kidney issues	_____	□ Serious depression	_____
□ Asthma	_____	□ Arthritis	_____	□ Emotional problems	_____
□ Chronic bronchitis	_____	□ Gout	_____	□ Nervous breakdown	_____
□ Emphysema	_____	□ Broken bones	_____	□ Other	_____
□ Tuberculosis	_____	□ Varicose veins	_____	□ Other	_____
□ Heart murmur	_____	□ Phlebitis or blood clots	_____	Women	
□ Heart attack	_____	□ Bleeding problems	_____	□ Menstrual difficulties	
□ Angina	_____	□ Anemia	_____	□ Abnormal PAP	
□ Enlarged heart	_____	□ Cancer (Type:_____)	_____	□ Ovarian cyst(s)	
□ Rheumatic fever	_____	□ Diabetes	_____	□ Breast lump(s)	
□ High blood pressure	_____	□ Overactive thyroid	_____	Men	
□ Hiatal hernia	_____	□ Underactive thyroid	_____	□ Prostate trouble	

Current Medications: (Include nonprescription products)		**Allergies: (include drugs, foods, chemicals, insects.)**	
Drug Name	**Dose**	**Item**	**Type of reaction**
1.		1.	
2.		2.	
3.		3.	