Welcome To Our Office

Name:_____ Today's Date:_____
First Middle Last

Home Address: _____
City:_____ State:_____ Zip:_____
Telephone: ( )_____ Birthdate:_____ Age:_____
Occupation:_____ SSN:_____
Employer:_____ Years There:_____
Employer's Address:_____
City:_____ State:_____ Zip:_____
Work Phone: ( )_____ Cell Phone: ( )_____
E-Mail:_____

Complete this section only if someone other than the patient is financially responsible (eg if patient is a minor or patient has a legal power of attorney for financial matters).

Responsible Party: _____ Relationship To Patient:_____
Home Address: _____
City:_____ State:_____ Zip:_____
Telephone: ( )_____ Birthdate:_____ Age:_____
Occupation:_____ SSN:_____
Employer:_____ Years There:_____
Employer's Address:_____
City:_____ State:_____ Zip:_____
Work Phone: ( )_____ Cell Phone: ( )_____

Name of Spouse:_____ Birthdate:_____ Age:_____
Occupation:_____ SSN:_____
Employer:_____ Years There:_____
Employer's Address:_____
City:_____ State:_____ Zip:_____
Employer's Telephone: ( )_____

In case of emergency, contact: _____ Relationship:_____
Home Phone: ( )_____ Work Phone: ( )_____

How did you learn about our facility?_____
Can we mail information to your home? Yes No
Can we leave a message for you at home? Yes No
Can we leave a message for you at work? Yes No
Can we send e-mail to you at the address provided? Yes No

Insurance Information

Name:_____ Today's Date:_____
First Middle Last

[Primary Insurance]
Name of Insurance Company:_____
Address:_____
City:_____ State:_____ Zip:_____
Insured's Name:_____
Insured's DOB:_____ Insured's SSN:_____
Group Number:_____ Policy ID Number:_____

[Secondary Insurance]
Name of Insurance Company:_____
Address:_____
City:_____ State:_____ Zip:_____
Insured's Name:_____
Insured's DOB:_____ Insured's SSN:_____
Group Number:_____ Policy ID Number:_____

Did your injury happen on the job? Yes No
If yes, on what date did the injury occur? _____
Did you report the accident to your employer? Yes No

Our office will file insurance for all reimbursement services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's visit: ___Cash ___Check ___Visa/MC ___AMEX

Signature of Patient or Responsible Party: _____

Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed:_____
(Patient or responsible party)

Date:_____

I authorize payment of medical and surgical benefits to Gregory H. Pastrick, MD.

Signed:_____
(Patient or responsible party)

Date:_____

HEALTH HISTORY
(CONFIDENTIAL)

NAME:_____ DATE:_____
AGE:_____ BIRTHDATE:_____ DATE OF LAST EXAM:_____
WHAT IS YOUR REASON FOR VISIT?_____

SYMPTOMS (You currently have or have had in past year, check □)

GENERAL
□Chills
□Depression
□Dizziness
□Fainting
□Fever
□Forgetfulness
□Headache
□Loss of Sleep
□Loss of Weight
□Nervousness
□Numbness
□Sweats

MUSCLE/JOINT/BACK
Pain,weakness,numbness in:
□Arms □Hips
□Back □Legs
□Feet □Neck
□Hands □Shoulders

GENITOURINARY
□Blood in urine
□Frequent urination
□Lack of bladder control
□Painful urination

GASTROINTESTINAL
□Appetite poor
□Bloating
□Bowel changes
□Constipation
□Diarrhea
□Excessive hunger
□Excessive thirst
□Gas
□Hemorrhoids
□Indigestion
□Nausea
□Rectal Bleeding
□Stomach Pain
□Vomiting
□Vomiting blood

CARDIOVASCULAR
□Varicose veins
□Chest pains
□High blood pressure
□Irregular heartbeat
□Low blood pressure
□Poor circulation
□Rapid heartbeat
□Swelling of ankles

EYE,EAR,NOSE,THROAT
□Bleeding gums
□Blurred vision
□Crossed eyes
□Difficulty swallowing
□Double vision
□Earache
□Ear discharge
□Hay fever
□Hoarseness
□Loss of hearing
□Nosebleeds
□Persistent cough
□Ringing in ears
□Sinus problems
□Vision - flashes
□Vision - halos

SKIN
□Sore that won't heal
□Bruise easily
□Hives
□Itching
□Change in moles
□Rash
□Scars

MEN ONLY
□Breast lump
□Erection difficulty
□Lump in testicle
□Penis discharge
□Sore on penis
□Other

WOMEN ONLY
□Abnormal pap
□Bleeding between periods
□Breast lump
□Extreme menstrual bleeding
□Hot flashes
□Nipple discharge
□Painful intercourse
□Vaginal Discharge
□Other
Date last menstrual period:

Date last Pap smear:

Have you had a mammogram?

Are you pregnant?

Number of children:

CONDITIONS (you have or have had in the past, check □)

□AIDS
□Alcoholism
□Anemia
□Anorexia
□Appendicitis
□Arthritis
□Asthma
□Bleeding disorders
□Breast lump
□Bronchitis
□Bulimia
□Cancer
□Cataracts
□Chemical dependency
□Chicken pox
□Diabetes
□Emphysema
□Epilepsy
□Glaucoma
□Goiter
□Gonorrhea
□Gout
□Heart disease
□Hepatitis
□Hernia
□Herpes
□High cholesterol
□HIV positive
□Kidney disease
□Liver disease
□Measles
□Migraine headaches
□Miscarriage
□Mononucleosis
□Multiple Sclerosis
□Mumps
□Pacemaker
□Pneumonia
□Polio
□Prostate problems
□Psychiatric problems
□Rheumatic fever
□Scarlet fever
□Stroke
□Suicide attempt
□Thyroid problems
□Tonsillitis
□Tuberculosis
□Typhoid fever
□Ulcers
□Vaginal Infections
□Venereal Disease

MEDICATIONS currently taking:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following		Relation to you
						Arthritis, gout	
Father						Asthma, hay fever	
Mother						Cancer -	
Brothers						Chemical dependency	
						Diabetes	
						Heart disease, stroke	
						High Blood Pressure	
Sisters						Kidney disease	
						Tuberculosis	
						Other -	

HOSPITALIZATIONS

Year	Hospital	Reason for hospitalizations and

PREGNANCY HISTORY

Year Of Birth	Date Of Birth	Complications

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate date:

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS – Check which substances you use and describe how much you use:

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS

Check of work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy lifting
	Other

Your Occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for omissions that I may have made in completion of this form.

_____

Signature Date

_____

Signature of Parent/Guardian Date