



2004 N. Hwy. 81 / Duncan, OK 73533  
580-255-0500 / 580-252-1684 (fax)

Name - Last \_\_\_\_\_ First \_\_\_\_\_ M \_\_\_\_\_  
MARITAL STATUS  
 DOB \_\_\_\_\_ Gender M F Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ S M W D Sep  
 HOME PH \_\_\_\_\_ WK PH \_\_\_\_\_ CELL \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 City/ST/Zip \_\_\_\_\_

**PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)**

Name - Last \_\_\_\_\_ First \_\_\_\_\_ M \_\_\_\_\_  
MARITAL STATUS  
 DOB \_\_\_\_\_ Gender M F Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ S M W D Sep  
 HOME PH \_\_\_\_\_ WK PH \_\_\_\_\_ CELL \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
 EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 CITY/ST/ZIP \_\_\_\_\_

**INSURANCE INFORMATION - Primary Insurance**

Policy Holder  
 Name - Last \_\_\_\_\_ First \_\_\_\_\_ M \_\_\_\_\_  
 Policy Holder  
 DOB \_\_\_\_\_ Gender M F Policy Holder  
 Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Policy Holder  
 HOME PH \_\_\_\_\_ WK PH \_\_\_\_\_ CELL \_\_\_\_\_  
 Policy Holder  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
 Policy Holder  
 EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 GROUP NUMBER POLICY NUMBER  
 NAME OF INSURANCE \_\_\_\_\_

**SECONDARY INSURANCE:**

Policy Holder  
 Name - Last \_\_\_\_\_ First \_\_\_\_\_ M \_\_\_\_\_  
 Policy Holder  
 DOB \_\_\_\_\_ Gender M F Policy Holder  
 Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Policy Holder  
 HOME PH \_\_\_\_\_ WK PH \_\_\_\_\_ CELL \_\_\_\_\_  
 Policy Holder  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_  
 Policy Holder  
 EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
 GROUP NUMBER POLICY NUMBER  
 NAME OF INSURANCE \_\_\_\_\_

**Before Check-In Can be Completed, You Must Read and Complete Second Side**

**PRIMARY EMERGENCY CONTACT INFORMATION**

Name - Last \_\_\_\_\_ First \_\_\_\_\_ M \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ PH #1 \_\_\_\_\_ PH#2 \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

**GENERAL CONSENT TO TREAT:** Agree and consent to the performance of diagnostic and therapeutic procedures deemed necessary by patient's provider. I acknowledge that there are no guarantees, expressed or implied, as the results of any procedures or medical treatment.

**RELEASE OF INFORMATION** I authorize the servicing provider and/or FamilMed staff on behalf of the patient to release all billing and medical information (including information concerning substance abuse and HIV status, if applicable) to physicians or institutions providing follow-up care; and to the Social Security Administration, Medicare, Medicaid (or their various intermediaries), the insurance company(s) health maintenance organization(s) employer, person acting on behalf of a preferred provider arrangement (or any of their agents or representatives) when such information is requested for payment, worker's compensation, utilization, review or coverage determination purposes. I also authorize the release of medical information to third parties as named below. I also authorize FamilyMed and/or their staff to leave call back messages on my answering machine/cell phone. I understand that this authorization remains completely and permanently in effect unless revoked by me in writing and delivered to FamilyMed clinic by certified mail.

Third Party Release: Name: \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_  
Address: \_\_\_\_\_ CITY/ST/ZIP: \_\_\_\_\_  
Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Third Party Release: Name: \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_  
Address: \_\_\_\_\_ CITY/ST/ZIP: \_\_\_\_\_  
Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Third Party Release: Name: \_\_\_\_\_ Relationship to Pt. \_\_\_\_\_  
Address: \_\_\_\_\_ CITY/ST/ZIP: \_\_\_\_\_  
Phone #: \_\_\_\_\_ E-mail: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE:** I authorize any insurance companies to pay directly to FamilyMed all benefits due and payable as a result of services rendered by same.

**ACKNOWLEDGE OF RESPONSIBILITY TO PAY FOR SERVICES:** I understand that FamilyMed, as a courtesy, will file claims with insurance carriers. However, I hereby acknowledge and agree that, except as provided by law and in consideration of the services provided, I will pay any all charges which, for any reason, are not paid by any third party payer. The only exception to the above is a written and signed agreement between the patient, payer and FamilyMed.

**MEDICARE PATIENTS:** Medicare will pay only for services it determines to be "reasonable and necessary". If services that the provider has requested/performed are denied for payment by Medicare, I agree to be personally and fully responsible for payment of any/all said charges.

PATIENT NAME (Please Print) \_\_\_\_\_ Date \_\_\_\_\_

SIGNATURE OF PATIENT/GUARANTOR/AUTHORIZED PERSON \_\_\_\_\_



2004 N. Hwy. 81  
Duncan, OK 73533  
580-255-0500  
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Today's Date: \_\_\_\_\_

In order for us to provide the very best comprehensive medical care, please complete the following form as accurately as possible. Please provide answers in every area, even if "not applicable" is the answer. If you need additional space for some information, please use the back of the form and indicate which area you are referencing (i.e Meds or Allergies).

### PERSONAL HISTORY

Name-Last \_\_\_\_\_ First \_\_\_\_\_ M \_\_\_\_\_

DOB \_\_\_\_\_ Gender: M F Race \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home PH \_\_\_\_\_ Cell PH \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

**MEDICATIONS** (Please include dosage, OTC, Vitamins, Herbals etc. and why you are taking):

1. \_\_\_\_\_ for \_\_\_\_\_

2. \_\_\_\_\_ for \_\_\_\_\_

3. \_\_\_\_\_ for \_\_\_\_\_

4. \_\_\_\_\_ for \_\_\_\_\_

5. \_\_\_\_\_ for \_\_\_\_\_

6. \_\_\_\_\_ for \_\_\_\_\_

Pharmacy Preference: \_\_\_\_\_ City \_\_\_\_\_

**ALLERGIES** (List medications, foods or conditions; your reaction to the item(s) and what you did.)

1. \_\_\_\_\_ reaction \_\_\_\_\_

2. \_\_\_\_\_ reaction \_\_\_\_\_

3. \_\_\_\_\_ reaction \_\_\_\_\_

4. \_\_\_\_\_ reaction \_\_\_\_\_

Who is your current Primary Care Provider \_\_\_\_\_ PH# \_\_\_\_\_

Are you wanting to establish/transfer your care with us? Y N

Other PROVIDERS (physicians) you are currently seeing or have in the last five years and why:

1. \_\_\_\_\_ for \_\_\_\_\_

2. \_\_\_\_\_ for \_\_\_\_\_

**CHRONIC MEDICAL PROBLEMS/CONDITIONS** (Please list all you have been diagnosed with, even ones that you did or do not take medications for.):

- 1. \_\_\_\_\_ when \_\_\_\_\_
- 2. \_\_\_\_\_ when \_\_\_\_\_
- 3. \_\_\_\_\_ when \_\_\_\_\_
- 4. \_\_\_\_\_ when \_\_\_\_\_
- 5. \_\_\_\_\_ when \_\_\_\_\_
- 6. \_\_\_\_\_ when \_\_\_\_\_

**PREVIOUS SURGERIES/HOSPITALIZATIONS:**

- 1. \_\_\_\_\_ when \_\_\_\_\_
- 2. \_\_\_\_\_ when \_\_\_\_\_
- 3. \_\_\_\_\_ when \_\_\_\_\_
- 4. \_\_\_\_\_ when \_\_\_\_\_

**FAMILY HISTORY** (Please list MEDICAL CONDITIONS of immediate family members):

Mother: _____	Father: _____
_____	_____
Sister: _____	Brother: _____
_____	_____
Maternal Grandmother: _____	Maternal Grandfather: _____
_____	_____
Paternal Grandmother: _____	Paternal Grandfather: _____
_____	_____

**PLEASE LIST** the two (2) main reasons you want to be seen today?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_ ~~SMW D SEP~~ **MARITAL STATUS** How Long? \_\_\_\_\_

If disabled, please list reason \_\_\_\_\_ Date Started \_\_\_\_\_

Who do you live with? \_\_\_\_\_ Relationship \_\_\_\_\_

Academics: Grade completed \_\_\_\_\_ Degree \_\_\_\_\_

Smoking/Dipping (now) Y N How much: \_\_\_\_\_ How long: \_\_\_\_\_

Alcohol use (now): Y N In the past: Y N How much: \_\_\_\_\_ Number of years: \_\_\_\_\_

Any illicit (street) drug use (now): Y N In the past: Y N What type(s): \_\_\_\_\_

**PEDIATRICS** (Please complete if patient is a minor):

Who else lives in the house: \_\_\_\_\_ Relationship: \_\_\_\_\_  
\_\_\_\_\_ Relationship: \_\_\_\_\_

Does anyone who comes in contact with the patient smoke: Y N Relationship \_\_\_\_\_

Parent(s) S M W D SEP Name of custodial parent \_\_\_\_\_

Is the child in daycare: Y N Birth Weight \_\_\_\_ lbs \_\_\_\_ ozs. Birth: Vaginal C-Section

Please list any/all complications: \_\_\_\_\_  
\_\_\_\_\_

**FEMALES ONLY:**

How many pregnancies: \_\_\_\_ How many living children: \_\_\_\_ Date last pap smear: \_\_\_\_\_

Result of pap smear: \_\_\_\_\_ Any abnormal pap smears in the past: Y N (Please explain)

List complications during pregnancy: \_\_\_\_\_  
\_\_\_\_\_

**MISCELLANEOUS:**

Last tetanus shot: \_\_\_\_\_ Last colonoscopy: \_\_\_\_\_

Other issues you believe your provider should be made aware of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_