

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 _____

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 580-252-1684 (fax)

PEDIATRIC

Today's Date: _____

Name: _____ Gender: M F Race: _____
LAST FIRST MIDDLE

SSN _____ - _____ - _____ Birthdate: _____ Wt. _____ lbs _____ oz _____ kg

Type of Delivery: _____ Complications: _____

Parent/Gardian: _____ Ph #: _____
LAST FIRST MIDDLE INITIAL

SOCIAL HISTORY: Family/Living Situation: _____
CHILD IS LIVING WITH WHO AND WHERE

School: _____ Child Care: _____

Drug Use: Y N - Explain: _____

Tobacco Use/Exposure - Explain: _____

Violence - Explain: _____

Sexual Activity - Explain: _____

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

1. _____ for _____

2. _____ for _____

3. _____ 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 _____

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 main reasons you want to be seen today?

IMMUNIZATIONS:

DPT	Polio	HIB	Hep B	Hep A	MMR	Varicella	Rotavirus
	2m,4m,6m 12-18m 4-6 yrs	2m,4m,6m	Birth, 1-2m 6-12 m	1st - 6-18m 2nd > 2 yrs.	12 - 15m 4 - 6 yrs.	1st - 12-15m 2nd 4-6 yrs.	2m,4m,6m
#1							
#2							
#3							
#4							
#5							