Health Professionals of Winfield

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Welcome to our Clinic

Patient First Name	Last Name
Date of Birth	Social Security Number

Gender: ☐Male ☐Female	Race	Marital Status: ☐S ☐M ☐W ☐D ☐Separated
Preferred Contact Method: ☐Email ☐Phone ☐Postal ☐Patient Portal	Appointment Notification Contact Method: ☐Email ☐Text Call: ☐Primary ☐Cell ☐Work	Email

Street Address	City	State	Zip

Primary Phone #	Work Phone #	Mobile/Other Phone #

Emergency Contact Last Name, First Name	Relationship	Phone #

Employer	Occupation	City, State, ZIP

Guarantor Name		Patient's Relationship to Guarantor
Date Of Birth	Social Security #	Address
Primary Phone #	Work Phone #	Employer

Primary Insurance Information	**Secondary Insurance Information**
Insurance Company:	Insurance Company:
Policy #:	Policy #:
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Please Check here if NO Insurance:	Please Check here if NO Insurance:

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Patient Name:	DOB:

PERSONAL MEDICAL HISTORY: PLEASE MARK ALL THAT APPLY

☐ ADHD	☐ COPD/Emphysema	☐ High Cholesterol	☐ Rheumatoid Arthritis
☐ Alcoholism	☐ Dementia	☐ HIV	☐ Seizure Disorder
☐ Allergies, Seasonal	☐ Depression	☐ Hepatitis	☐ Sleep Apnea
☐ Anemia	☐ Diabetes: 1 or 2	☐ Irritable Bowel Syndrome	☐ Stroke
☐ Anxiety	☐ Diverticulitis	☐ Lupus	☐ Thyroid Disorder
☐ Arrhythmia	☐ DVT	☐ Liver Disease	☐ Ulcerative Colitis
☐ Arthritis	☐ GERD	☐ Macular Degeneration	☐ Neuropathy
☐ Asthma	☐ Glaucoma	☐ Osteoporosis	**Other not listed:**
☐ Bipolar	☐ Heart Disease	☐ Osteopenia	
☐ Bladder Problems	☐ Heart Attack	☐ Parkinson's Disease	
☐ Bleeding Problems	☐ Hiatal Hernia	☐ Peripheral Vascular Disease	
☐ Cancer:			
☐ Headaches	☐ High Blood Pressure	☐ Peptic Ulcer	
☐ Kidney Stones	☐ Psoriasis	☐ Crohn's Disease	
☐ Kidney Disease	☐ Pulmonary Embolism		

ALLERGIES:

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Patient Name:	DOB:

SURGICAL HISTORY: PLEASE LIST ALL PRIOR SURGERIES AND APPROXIMATE DATES PERFORMED

Surgery	Date

Last Menstrual Period	Date	☐ Normal ☐ Abnormal
Colonoscopy	☐ Yes ☐ No Date:	☐ Normal ☐ Abnormal
Mammogram	☐ Yes ☐ No Date:	☐ Normal ☐ Abnormal
Dexa (Bone Density)	☐ Yes ☐ No Date:	☐ Normal ☐ Abnormal
PSA	☐ Yes ☐ No Date:	☐ Normal ☐ Abnormal

	Frequency	Last Time Was?
Tobacco Use		
Alcohol Use		
Drug Use		
Caffeine		
Exercise		

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Patient Name:	DOB:

Medication	Dosage	Frequency

Preferred Pharmacy:

Pharmacy Name:	Address	Phone Number

Patient Name:	**DOB:**

SOCIAL / CULTURAL HISTORY:

Education Level	Elementary	High School	Vocational	College	Graduate/Professional

Do you have any vision problems that affect your communication? ☐Yes ☐No

Do you have hearing problems that affect your communication? ☐Yes ☐No

Do you have any limitations to understanding and / or following instructions ☐Yes ☐No

Who lives in the home:

Number of Children:

List Any Family Medical History:

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Patient Name:	DOB:

Authorization to release information:
I authorize for information regarding my medical care to be released to the following person(s) if she or he so requests:

Name	Relationship to Patient	Phone Number

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any information required for claim(s) submission to my insurance company(s). I also authorize that payments be made directly to Health Professionals of Winfield.

Signature: _____ Date: _____

Parent, if minor: _____ Date: _____