Shasta Regional Medical Group

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I_____

Address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Age: _____ Gender: Male [ ] Female [ ] Transgender [ ]

Phone Number: home [ ] _____ cellphone [ ]_____

Email _____

Social Security #: _____Marital Status: Married [ ] Single [ ] Divorced [ ] Widowed [ ]

Race: American Indian or Alaska Native [ ] Black of African American [ ] Hispanic [ ]

White [ ] Asian [ ] Native Hawaiian or other Pacific Islander [ ] Other [ ]

Primary Language: _____ Do you need an interpreter? _____

Is your visit due to an injury? Yes [ ] No [ ] If yes, date of injury: _____

Where did the injury occur? Work [ ] Auto [ ] Home [ ] School [ ] Other [ ]_____

Previous Primary Care Provider: _____

List any other medical providers you see on a regular basis (ex. Cardiologist, Mental Health Provider, Kidney Doctor, Dentist, etc..) _____

_____

Guarantor Information:

Same as patient: [ ] Employer: _____

Name: _____ Date of birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance:

Insured Party: _____ Relationship to patient: _____

Date of birth: _____ Social Security #: _____

Insurance Carrier: _____ ID# _____

Policy/Group # _____

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Secondary Insurance:

Insured Party: _____ Relationship to patient: _____

Date of birth: _____ Social Security #: _____

Insurance Carrier: _____ ID# _____

Policy/Group # _____

Emergency Contacts:

Name: _____ Relationship: _____

Phone Number: home [ ] _____ cellphone [ ]_____

Name: _____ Relationship: _____

Phone Number: home [ ] _____ cellphone [ ]_____

I hereby authorize and consent to examination and treatment deemed necessary by the medical providers of Shasta Regional Medical Group. I authorize release of information to my insurance carrier should it be necessary. The undersigned agrees to pay any cost incurred by Shasta Regional Medical Group in the collection of amounts due including, but not limited to, reasonable attorney's fees.

I hereby assign all medical and/or surgical benefits, including major benefits to which I am entitled including Medicare, private insurance and other health plans to Shasta Regional Medical Group. The assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I further authorize the release of all information necessary to secure payment.

I understand and agree that payment by the responsible party will not be delayed or withheld because of any dispute between the responsible party and any insurance company, reimbursing agency, third party or because of pending legal claims.

Responsible Party: _____ Date: _____

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Last Name: _____ First Name: _____ M.I_____

Allergies: _____

PERSONAL MEDICAL HISTORY: (Please circle 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 (Acid Reflux)
Macular Degeneration
Neuropathy
Bipolar Disorder
Heart Disease
Glaucoma
Osteopenia/Osteoporosis
Bladder Problems
Heart Attack MI
Parkinson's Disease
Peptic Ulcer
Bleeding Problems
Hiatal Hernia
Peripheral Vascular Disease
Pulmonary Embolism (PE)
Crohn's Disease
High Blood Pressure
Kidney Stones
Kidney Disease
Cancer:
_____

Please list any other medical problems not listed above:

_____

_____

Please include a copy of all immunizations.

List **ALL MEDICATIONS** you take, including over-the-counter (OTC) medications and vitamins.

NAME	DOSE	FREQUENCY

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List ALL SURGERIES

Type of Surgery	Reason for Surgery	Year

Social and Family History:

Have you ever used tobacco products? Yes [ ] No [ ]

If yes, what type: _____ Quantity/Amount: _____

If you have quit, how long ago? _____ How many years? _____

Are you currently exposed to second hand smoke? Yes [ ] No [ ]

Do you consume alcoholic beverages? Yes [ ] No [ ]

If yes, frequency_____ and amount _____.

Do you use recreational drugs, such as marijuana, cocaine and/or methamphetamine? Yes [ ] No [ ]

If yes, what type: _____ Quantity/Amount: _____

List ALL Family History:

	Living	Deceased	Age	Medical Problems
Mother				
Father				
Sister				
Sister				
Brother				
Brother				
Grandfather (paternal)				
Grandfather (maternal)				
Grandmother (paternal)				
Grandmother (maternal)				
Other				
Other				

Patient Signature: _____ Date: _____

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Systems Review

As your review the following list, please check any of those problems, which have significantly affected you.

CONSTITUTIONAL
- ☐ Recent weight gain Amount _____
- ☐ Recent weight loss Amount _____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever

EYES
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Itching eyes

EAR-NOSE-MOUTH-THROAT
- ☐ Bleeding gums
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Runny nose
- ☐ Sores in mouth
- ☐ Loss of taste
- ☐ Dryness of mouth
- ☐ Frequent sore throats
- ☐ Difficulty in swallowing

CARDIOVASCULAR
- ☐ Pain in chest
- ☐ Heart murmurs
- ☐ Irregular heart beat
- ☐ Sudden changes in heart beat
- ☐ High blood pressure

MUSCULOSKELETAL
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Muscle tenderness

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting blood or coffee ground like material
- ☐ Stomach pain relieved by food or milk
- ☐ Blood in stools
- ☐ Jaundice
- ☐ Persistent diarrhea
- ☐ Black stools
- ☐ Heartburn
- ☐ Increasing constipation

GENITOURINARY
- ☐ Difficult urination
- ☐ Pain or burning on urination
- ☐ Rash/ulcers
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Cloudy urine
- ☐ Discharge from penis/vagina
- ☐ Getting up at night to urinate
- ☐ Sexual difficulties
- ☐ Vaginal dryness

RESPIRATORY
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Wheezing
- ☐ Swollen legs or feet
- ☐ Cough
- ☐ Coughing up blood

INTEGUMENTARY (SKIN AND/OR BREAST)
- ☐ Easy bruising
- ☐ Redness
- ☐ Rash
- ☐ Hives
- ☐ Hair loss
- ☐ Tightness
- ☐ Nodules/bumps
- ☐ Color changes of hand or feet in the cold

NEUROLOGICAL
- ☐ Headaches
- ☐ Dizziness
- ☐ Night sweats
- ☐ Sensitivity or pain of hands and/or feet
- ☐ Memory loss
- ☐ Fainting
- ☐ Muscle spasm
- ☐ Loss of consciousness

HEMATOLOGIC/LYMPHATIC
- ☐ Blood transfusion? When _____
- ☐ Swollen glands
- ☐ Anemia
- ☐ Bleeding tendency

PSYCHIATRIC
- ☐ Excessive worries
- ☐ Easily losing temper
- ☐ Anxiety
- ☐ Depression
- ☐ Difficulty falling/staying asleep

ENDOCRINE
- ☐ Excessive thirst

ALLERGIC/IMMUNOLOGIC
- ☐ Frequent sneezing
- ☐ Increased susceptibility to infection