Main Street Medical Clinic, P.A. **Internal Medicine & Pediatrics**

Patient Information

Name: _____
(first) (middle) (last)
Nickname:_____
Marital Status: S M D W Gender: M F
Birthdate: _____ Age:_____
Home Address: _____
City: _____ State:____ Zip:_____
Email: _____
Phone:( )_____
Cell # :( )_____
Soc. Sec.#: _____
Employer Name:_____
Employer Phone: ( )_____

Responsible Party Information

Name: _____
(first) (middle) (last)
Marital Status: S M D W Gender: M F
Relationship to Patient: _____
Address: _____
City: _____ State:____ Zip:_____
Email: _____
Phone:( )_____
Soc. Sec.#: _____ DL# _____
Date of Birth: _____

If patient is a child, please complete the following:

Mother Guardian Stepmother

Name: _____
Address: _____
City: _____ State:____ Zip:_____
Phone: ( )_____
Employer Name: _____
Occupation: _____
Employer Phone: ( )_____
Soc. Sec.#: _____ DL# _____
Date of Birth: _____

Father Guardian Stepfather

Name: _____
Address: _____
City: _____ State:____ Zip:_____
Phone: ( )_____
Employer Name: _____
Occupation: _____
Employer Phone: ( )_____
Soc. Sec.#: _____ DL# _____
Date of Birth: _____

Additional Patient Information

***Patient's Race (check one):**

☐ American Indian / Alaska Native ☐ Asian
☐ Black / African American ☐ White
☐ Native Hawaiian / Other Pacific Islander ☐ Other
☐ Declined

***Patient's Ethnicity (check one):**

☐ Hispanic or Latino ☐ Not Hispanic or Latino
☐ Declined

***Patient's Preferred Language (check one):**

☐ English ☐ Spanish ☐ French
☐ Arabic ☐ Chinese ☐ German
☐ Japanese ☐ Russian ☐ Other _____

**The collection of this information is legal and authorized under Title VI of the Civil Rights Act of 1964. The purpose of gathering this information is to improve the overall quality of healthcare offered. The information gathered is helpful in measuring trends, identifying disparity gaps in healthcare, and implementing targeted intervention toward specific populations that may be at a higher risk for certain illnesses. This information will never be used to profile patients or discriminate against patients in any way.*

Primary Insurance

Insurance Name: _____
Insurance Address: _____
City: _____ State:____ Zip:_____
Phone: ( )_____
Effective Date: _____
Policy #: _____
Group #: _____
Insured Name: _____
Insured DOB: _____
Relationship to Patient: _____
Insured Employer: _____

Secondary Insurance

Insurance Name: _____
Insurance Address: _____
City: _____ State:____ Zip:_____
Phone: ( )_____
Effective Date: _____
Policy #: _____
Group #: _____
Insured Name: _____
Insured DOB: _____
Relationship to Patient: _____
Insured Employer: _____

Authorization and Release

I authorize ***Main Street Medical Clinic, P.A.*** to release any information including the records of any treatment or examination rendered during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to ***Main Street Medical Clinic, P.A.*** benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf for myself or my dependents.

_____
Signature of Patient or Parent or Guardian of Minor Child

_____
Date

Patient Name (Printed):_____ Date of Birth: _____

Patient Acknowledgement of Receipt of Notice of Privacy Practices

A copy of our current Notice of Privacy Practices is provided to you as a new patient. Copies are also available at the front desk and on our website. If you have any questions regarding the information in Main Street Medical Clinic's Notice of Privacy Practices, please do not hesitate to contact a clinic representative or the Main Street Medical Clinic Patient Privacy Officer as indicated on the Notice.

Patient Acknowledgement of Receipt of Financial Policy

A copy of our current Financial Policy is provided to you as a new patient. Copies are also available at the front desk and on our website. If you have any questions regarding our Financial Policy, please contact our billing office at (501) 315-0059.

I have received a of the clinic's Notice of Privacy Practices. I have also received a copy of the Financial Policy and understand the terms contained within.

_____ _____ _____

Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

Consent to Obtain Medication History from Pharmacies through e-Prescribing:

I hereby give my consent to Main Street Medical Clinic, including its licensed practitioners and employees, to access, use and disclose my protected health information to any pharmacies I currently use or will use in the future for the purpose of transmitting prescriptions to them for my treatment. I consent to the disclosure of my prescription medication information by any provider, mental health provider, pharmacy, insurer or prescription benefits manager, specifically including any state or federal health program to Main Street Medical Clinic and pharmacies for the purpose of my treatment. My consent includes the re-disclosure of protected health information maintained by a drug or alcohol treatment program.

_____ _____ _____

Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

Access to Patient Portal

I understand that access to the Patient Portal is voluntary and acknowledge that I have read and fully understand the terms contained in the Patient Portal information sheet provided to me and understand that there are confidentiality risks associated with any type of online communication, including Main Street Medical Clinic's Patient Portal.

_____ _____ _____

Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

Patient Name (Printed):_____ Date of Birth: _____

Request for Confidential Communications Regarding Medical Information:

I request that Main Street Medical Clinic communicate with me confidentially about medical matters in the following manner:

Patient's Preferred Method for Contact & Reminders:

☐ Phone Call # _____

☐ Text Cell #_____

☐ Email** _____

☐ Mail

***Our office does not currently have the ability to send secure, HIPAA-compliant email. If you select this option, you will receive an email with instructions to sign up for our patient portal, which you can use to communicate with our office securely.*

Designation of Certain Relatives, Close Friends and Other Caregivers as my Personal Representative:

I agree that the Main Street Medical Clinic may disclose certain information about my health care to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, Main Street Medical Clinic will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. These designated persons are listed below (Please note: If you want to allow us to disclose PHI to your spouse, his/her name MUST be listed):

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

The following person(s) <u>are not authorized</u> to receive my Patient Health Information (PHI):

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

_____ _____ _____

Signature of Patient or Legal Representative ***Date*** ***Relationship to Patient***

Patient Name: _____ **Date of Birth:** _____

Medical History

		Details/Describe
ADD/ADHD	__ No __ Yes	_____
Anemia	__ No __ Yes	_____
Arthritis	__ No __ Yes	_____
Asthma	__ No __ Yes	_____
Blood Disorder/HIV	__ No __ Yes	_____
Cancer	__ No __ Yes	Type: _____
Depression	__ No __ Yes	_____
Diabetes	__ No __ Yes	_____
Emphysema	__ No __ Yes	_____
Heart Disease	__ No __ Yes	_____
Hepatitis	__ No __ Yes	_____
High Blood Pressure	__ No __ Yes	_____
High Cholesterol	__ No __ Yes	_____
Kidney Disease	__ No __ Yes	_____
Lung Disease	__ No __ Yes	_____
Migraines	__ No __ Yes	_____
Prostate Problems	__ No __ Yes	_____
Seizure	__ No __ Yes	_____
Skin Cancer	__ No __ Yes	_____
Stroke	__ No __ Yes	_____
Thyroid Disease	__ No __ Yes	_____
Ulcers	__ No __ Yes	_____

Other _____

Other _____

Other _____

Other _____

Other _____

Other _____

Are you currently under the care of any other physicians? Please list:

_____

_____

_____

_____

Previous Surgeries:

	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications:

	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Preferred Pharmacy(ies):

_____

_____

Allergies:

_____	_____
_____	_____
_____	_____
_____	_____

Pediatric History (for patients under 18 years old)

Which pregnancy was this child? _____

What was the mother's age at birth? _____

What was the birth weight? _____

☐ Vaginal ☐ Caesarean _____

# of days baby stayed in hospital after birth _____

Hospital where child was born _____

Are your child's immunizations up to date? _____

History of chickenpox? ☐ No ☐ Yes Date: _____

Is your child regularly exposed to second-hand smoke? ☐ No ☐ Yes

Please list names of others in the household:

Name:	*DOB:*	*Relationship:*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: _____ **Date of Birth:** _____

Social History

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Place of Employment/Occupation: _____

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of Tobacco:

☐ Never

☐ Cigarettes ☐ Previously, but quit (date) _____ ☐ Currently smoke _____ packs/day

☐ Cigars ☐ Previously, but quit (date) _____ ☐ Currently smoke _____ /day

☐ Smokeless Tobacco ☐ Previously, but quit (date) _____ ☐ Currently use_____ times/day

Use of Caffeine: ☐ Never ☐ Rarely ☐ Moderate – servings per day _____

Use of Drugs: ☐ Never ☐ Yes-Type/Frequency: _____

Family History

Have any of your blood relatives had the following? **Please check:**	Father	Mother	Brother	Sister	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Cancer (list type):								
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐
Other:								
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐

Please list any other information you would like the physician to know:

_____

_____

_____

_____

_____

Physician Signature _____ ***Date*** _____

REVIEW OF SYSTEMS

Patient Name: _____ **Date of Birth** _____

	Please circle	
Constitutional Symptoms:		
Fever	No	Yes
Headaches	No	Yes
Fatigue	No	Yes
Recent weight change	No	Yes
Eyes:		
Blurred or double vision	No	Yes
Wear contacts/glasses	No	Yes
Eye disease or injury	No	Yes
Ears/Nose/Throat:		
Swollen glands in neck	No	Yes
Chronic sinus problems	No	Yes
Earaches or drainage	No	Yes
Sore throat or voice change	No	Yes
Cardiovascular:		
Chest pain	No	Yes
Swelling of feet, ankles, or hands	No	Yes
Shortness of breath while walking or lying flat	No	Yes
Heart problems	No	Yes
Respiratory:		
Chronic cough	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes
Gastrointestinal:		
Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Rectal bleeding or blood in stool	No	Yes
Abdominal pain	No	Yes
Genitourinary:		
Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Change in force of strain	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Pain with periods	No	Yes
Irregular periods	No	Yes
Female:		
Vaginal discharge	No	Yes

# of pregnancies _____

# of miscarriages _____

Date of last pap smear _____

	Please circle	
Musculoskeletal:		
Joint pain	No	Yes
Back pain	No	Yes
Joint stiffness or swelling	No	Yes
Difficulty in walking	No	Yes
Muscle pain or cramps	No	Yes
Integumentary:		
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Breast pain	No	Yes
Breast discharge	No	Yes
Breast lump	No	Yes
Varicose Veins	No	Yes
Neurological:		
Head injury	No	Yes
Paralysis	No	Yes
Tremors	No	Yes
Numbness or tingling	No	Yes
Convulsions or seizures	No	Yes
Psychiatric:		
Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes
Endocrine:		
Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Skin becoming drier	No	Yes
Heat or cold intolerance	No	Yes
Hematologic/Lymphatic:		
Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic:

Food allergies:

_____

_____

Drug allergies:

_____

_____

_____

_____

_____

Patient Signature or Signature of Parent/Legal Guardian

_____

Date Signed

_____ _____

Physician Signature ***Date Signed***