Rincon Medical Center

Established Patient Information Sheet

Today's Date_____

Patient Name_____DOB_____AGE____

Symptoms for today's visit: _____

☐ **Result of a vehicle accident** ☐ **Result of a work related injury**

When did symptoms begin_____ Pain Scale (1=mild - 10=Extreme) _____

What Medications are you currently taking? ☐ List on File

Medicine Name	Dosage	Frequency

Are you Allergic to any Medications? _____ **If Yes, Please List** _____

Would you be interested in filling your prescription within the office? No ☐ Yes ☐

(Most medications cost $10.00 per prescription)

Female: When was your last normal period? _____ Are you pregnant? _____ Are you breastfeeding? ____

Since your last visit at Rincon Medical Center has there been any change in:

Address: No ☐ ☐ Yes, explain_____

Phone: No ☐ ☐ Yes, explain_____

Insurance: No ☐ ☐ Yes, explain_____

Surgical History: No ☐ ☐ Yes, explain_____

Medical History: No ☐ ☐ Yes, explain_____

Family Medical History: No ☐ ☐ Yes, explain_____

Tobacco Use: No ☐ ☐ Yes, explain_____

Alcohol Use: No ☐ ☐ Yes, explain_____

Drug Use: No ☐ ☐ Yes, explain_____

The signature below serves as authorization for medical treatment by the physician or nurse. It also provides authorization to **Rincon Medical Center** to furnish and/or release any information necessary to your insurance carrier, third party administration, and or health benefit payer representatives in order to process health care claims. This authorization also serves as permission to release my medical records to my designated primary care physician's office to ensure continuity of care. . I understand that I may withdraw this authorization to release medical information at any time, when I communicate in writing. I acknowledge that **Rincon Medical Center** will file my insurance as a courtesy, but it is my responsibility to understand my insurance coverage. I understand that I am financially responsible at the time of service for all co-payments, deductibles, balances not covered by the insurance carrier, and any previous balances owed.

Patient/Responsible Party Signature: _____ **Date:** _____

Physician Signature_____ Date_____