Republic Family Medicine llc

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Patient Information

Last Name: _________________________ **First Name:** ______________________ **M.I.** ______

Date of Birth: ________________ **Sex: ( ) M ( ) F Weight:** ___________ **Height:** __________

Home Phone: _________________________ **Cell Phone:** ___________________________

Address: __________________________ **City:** ______________ **State:** ___ **Zip:** _________

Email: ____________________________________ **SSN:** _____________________________

Marital Status: ______________________ **Referred by:** ____________________________

Pharmacy preference:

____

Other physicians involved in your care:

____

Reason for today's visit:

____

Allergies: (Medication/Food, indicate reaction) ( ) None

____

Medication List: (Please list name/dose/frequency if known)

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Family History: (Please indicate deceased or alive, medical issues and age)

Children: ____

Father: ____

Mother: ____

Siblings: ____

Grandparents: ____

IN CASE OF EMERGENCY

Name of local friend or relative: ____

Relationship to patient: ______________________________________

Home Phone: ________________ **Cell Phone:** _______________ **Work Phone:** ________________

The above information is true to the best of my knowledge. I authorize Republic Family Medicine, LLC to act as my agent in helping obtain payment from my insurance company. I authorize my insurance benefits to be paid directly to Republic Family Medicine, LLC. I understand that I am financially responsible for any balance, and for any co-payments and/or yearly deductible as specified under my insurance contract. I also authorize Republic Family Medicine, LLC or my insurance company to release any information required to process my claims. I permit this form to be used as “Signature on File” for all my insurance submissions

Patient/Guardian Signature: _____________________________ **Date:** ____/____/______

Relationship of Guardian: _________________________