L. William Roberts, M.D.
Cammual D. Suttor, M.D.
805 Alexa Drive
Mt. Sterling, KY 40353
(859) 498-5105

Patient's Full Name: ______________________________

Patient's Birth date: ____________ **Social Security Number:** ____________

Sex: ☐ **Male** ☐ **Female**
Marital Status: ☐ **Married** ☐ **Single** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Street Address: ______________________________

Home Phone #: ____________ **Work #:** ____________ **Cell #:** ____________

Spouse's Name: ______________________________

If child, Parent / Guardian Name: ____________ **Birth date:** ____________

Currently: ☐ **Employed** ☐ **Unemployed** ☐ **Disability** ☐ **Retired**

Employer / Company Name: ____________ **Phone #:** ____________

Family Doctor's Name: ____________ **Referred by:** ____________

Primary Insurance Name: ______________________________

Secondary Insurance Name: ______________________________

Pharmacy Name and Address: ____________ **City:** ____________

PLEASE HAVE INSURANCE CARDS & PHOTO ID READY TO SCAN.
(If you do not have your cards with you at the time of service, you will be asked to reschedule or pay for the full amount charged.)

I understand that I will be held financially responsible for any balances incurred in this office or charges that are not paid by myself, insurance company due to annual deductibles, co-pay amounts, and NSF checks / accounts closed. If any balance is not pad when due, I agree to pay all costs of collections, including reasonable attorney fees, court costs, and the collection agency's fees. If any insurance plan requires a pre-authorization from my PRIMARY CARE PHYSICIAN, I am responsible for obtaining the pre-cert number prior to the appointment. If this has not been done, I will be asked to pay for my visit or asked to reschedule the appointment until this required information is obtained. (We do accept Medicare assignment; however, you will be responsible for deductibles and co-pay amounts.)

AUTHORIZATION: I hereby authorize the above provider(s) to release any information regarding services rendered by him to my health insurance company and, in the case of Medicare, to the HCFA and its agents; and allow a photocopy of my signature to be used to file insurance, including Medicare, when applicable. I request the payment, including Medicare authorized benefits, be made either to me or on my behalf to the above named provider(s). I authorize and direct my insurer to issue payment for authorized benefits due me when the services rendered by the above named provider(s) to be made directly to him. And, regardless of my health insurance benefits, if any, I understand I am financially responsible for the fees for covered services and any costs incurred.

This authorization includes supplemental policy to: ______________________________
(Supplemental Insurance Carrier Name)

MEDICATION HISTORY CONSENT: I give permission for **L. William Roberts, M.D. or Cammual Suttor, M.D.** to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Signed: ______________________________ Date: ____________

PLEASE COMPLETE AND RETURN TO FRONT DESK W/INSURANCE CARDS
WE ACCEPT CASH, CHECKS, VISA AND MASTERCARD

Patient's Name: ______________________ Date: ______________

MEDICATIONS / ALLERGY HISTORY

Note: If you have a list, please give to clinical staff.

List all prescription medicine, including inhalers, nasal sprays, topical medicine…
List all vitamins, minerals, herbal / health supplements (e.g., Valerian)…
List any other non-prescription meds you take (e.g. Benadryl, Melatonin, Tylenol)…

NAME	DOSAGE
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

List all medications you are allergic to or react badly to (and describe the reaction).

MEDICATION	REACTION
1.	
2.	
3.	
4.	

List all allergies to animals, plants, dust, food, etc… ***(Describe reactions)***

____

____

Did you ever have an x-ray test where dye (contrast) was injected into your vein? ☐ **Yes** ☐ **No**
If yes, describe any allergic reaction or side effects from the dye.

____

____

Have you ever had allergy testing (skin testing)? ☐ **Yes** ☐ **No**
Have you ever received allergy shots? ☐ **Yes** ☐ **No When:** ______________

When and where did you get your last…

Flu Shot (influenza vaccine)? ______________ Pneumonia vaccine? ______________

PPD (TB skin test)? ______________ Chest X-Ray? ______________

MEDICAL HISTORY

Please check [X] all medical conditions you have or have had in the past.

☐ Allergies
☐ Arthritis
☐ Asthma
☐ Bleeding Disorders
☐ Blood Clots in the lung
☐ Breast Cancer
☐ Cancer
☐ Diabetes
☐ Esophageal Dysmotility
☐ Emphysema
☐
☐ Hay Fever
☐ Heart Disease
☐ Heartburn / Reflux
☐ Hiatal Hernia
☐ High Blood Pressure
☐
☐ Pneumonia
☐ Pulmonary Fibrosis
☐ Shortness of Breath
☐ Thyroid Disease
☐ ______________
☐ **Back Injury (Answer only if you are having a physical or workers comp)**

Patient's Name: ______________________________ **Date:** __________________

SOCIAL HISTORY

Check the appropriate boxes that apply:

☐ Current Smoker

__________ Total Years Smoking

__________ How old were you when you started?

☐ Former Smoker ☐ Never Smoked

☐ Alcohol / Caffeinated Beverages use

YES **NO** **Alcohol** If yes, how much per day? _____ Per week? _____

YES **NO** **Caffeinated Drinks** If yes, how much per day? _____ Per week? _____

☐ What hazardous materials, fumes, dusts, chemicals, and etc have you been exposed to at work or associated within your hobbies? ___________________________________

(e.g. *exotic birds, bird feathers, grain dust, moldy hay, solder, asbestos, paint fumes, Beryllium, welding, sand blasting, heavy metals, pesticides, baking flour dust)*

SURGICAL HISTORY

List all surgeries you have had (lifelong):		**List all non-surgical hospitalizations:**	
Type of Surgery	**Date of Surgery**	**Type of Non-Surgical Hospitalizations**	**Date of Surgery**
1.		**1.**	
2.		**2.**	
3.		**3.**	
4.		**4.**	
5.		**5.**	
6.		**6.**	
7.		**7.**	
8.		**8.**	
9.		**9.**	
10.		**10.**	

Patient's Name: ______________________________ **Date:** ____________________

FAMILY HISTORY

Please check [X] all medical conditions that any IMMEDIATE family members have or have had in the past.

- ☐ Allergies — Family Member(s): ____________________
- ☐ Arthritis — Family Member(s): ____________________
- ☐ Asthma — Family Member(s): ____________________
- ☐ Bleeding Disorders — Family Member(s): ____________________
- ☐ Blood Clots in the lung — Family Member(s): ____________________
- ☐ Breast Cancer — Family Member(s): ____________________
- ☐ Cancer — Family Member(s): ____________________
- ☐ Diabetes — Family Member(s): ____________________
- ☐ Esophageal Dysmotility — Family Member(s): ____________________
- ☐ Emphysema — Family Member(s): ____________________
- ☐ Hay Fever — Family Member(s): ____________________
- ☐ Heart Disease — Family Member(s): ____________________
- ☐ Heartburn / Reflux — Family Member(s): ____________________
- ☐ Hiatal Hernia — Family Member(s): ____________________
- ☐ High Blood Pressure — Family Member(s): ____________________
- ☐ Pneumonia — Family Member(s): ____________________
- ☐ Pulmonary Fibrosis — Family Member(s): ____________________
- ☐ Shortness of Breath — Family Member(s): ____________________
- ☐ Thyroid Disease — Family Member(s): ____________________
- ☐ ____________________ Family Member(s): ____________________
- ☐ ____________________ Family Member(s): ____________________
- ☐ ____________________ Family Member(s): ____________________
- ☐ ____________________ Family Member(s): ____________________
- ☐ ____________________ Family Member(s): ____________________
- ☐ ____________________ Family Member(s): ____________________

Patient's Name: ______________________________ **Date:** ________________

REVIEW OF SYSTEMS

Since Your Last Visit, Have you had any of the following conditions?

Constitutional	Yes	No
Good health lately	☐	☐
Recent weight loss	☐	☐
Fever	☐	☐
Fatigue	☐	☐
Weight Gain	☐	☐

Eyes	Yes	No
Eye disease	☐	☐
Blurred vision	☐	☐
Glaucoma	☐	☐

Ears / Nose / Mouth / Throat	Yes	No
Hearing loss	☐	☐
Ringing in the ears	☐	☐
Mouth sores	☐	☐
Bad taste	☐	☐
Sore tongue	☐	☐
Sore throat	☐	☐

Cardiovascular	Yes	No
Chest pain	☐	☐
Heart murmur	☐	☐
Swelling of ankles	☐	☐
Leg pain	☐	☐
Leg cramps when walking	☐	☐
Shortness of breath w/exertion	☐	☐
Palpitations / Skip beats	☐	☐

Respiratory	Yes	No
Chronic cough	☐	☐
Spitting up blood	☐	☐
Wheezing	☐	☐
Shortness of Breath	☐	☐

Gastrointestinal	Yes	No
Poor appetite	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Abdominal Pain	☐	☐
Diarrhea	☐	☐
Indigestion	☐	☐
Blood w/bowel movement	☐	☐
Problem swallowing	☐	☐
Constipation	☐	☐
Reflux	☐	☐
Gas	☐	☐

Genitourinary	Yes	No
Burning with urination	☐	☐
Incontinence of urine	☐	☐
Irregular periods	☐	☐
Trouble start/stop urination	☐	☐

Musculoskeletal	Yes	No
Joint pain or swelling	☐	☐
Back pain	☐	☐
Muscle pain	☐	☐
Stiffness	☐	☐

Skin	Yes	No
Rash	☐	☐
Discoloration	☐	☐
Mole	☐	☐

Neurological	Yes	No
Headaches	☐	☐
Weakness	☐	☐
Tremor / Shaking	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Seizures / Spells	☐	☐

Psychiatric	Yes	No
Depression	☐	☐
Anxiety	☐	☐
Insomnia	☐	☐
Excessive sleeping	☐	☐

Endocrine	Yes	No
Heat or cold intolerance	☐	☐
Frequent urination	☐	☐
Goiter	☐	☐
Hair loss	☐	☐

Hematological	Yes	No
Bleeding or bruising	☐	☐
Night sweats	☐	☐