Springhill Physician Practices

Dr. T. Ashton Blessey * Dr. Eric G. Becker * Dr. Michael Ederer * Dr. Michael Ledet * Dr. Lindsay Yarbrough
Meeta Nicholas, CRNP * Kimberly Ochab, CRNP * Sara Welch, PA * Sharon Noland, CRNP * Karen Cox, PA * Stacy Richerson, PA

3715 Dauphin Street, Suite 7-A * 1924 - K Dauphin Island Parkway
Phone: (251) 410-4001 * Fax: (251) 410-4002

Patient Information

Name: _____ Birth Date: _____ SSN: _____

Address: _____ Marital Status: _____

Home Phone: _____ Cell Phone: _____ email _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Referred by: _____ May we contact you via e-mail about reminders, results or other information? ☐ Yes ☐ No

Spouse/Responsible Party Information

Name: _____ Birth Date: _____ Relation: _____

Address: _____

Home Phone: _____ Cell Phone: _____ SSN: _____

Employer: _____ Work Phone: _____

May we contact in case of emergency or to notify of appointment? ☐ Yes ☐ No

Insurance Information

Primary Insurance Company: _____

Address: _____

Subscriber Name: _____ Birth Date: _____ SSN: _____

Insurance Policy #: _____ Group #: _____

Seconday Insurance Company: _____

Address: _____

Subscriber Name: _____ Birth Date: _____ SSN: _____

Insurance Policy #: _____ Group #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Springhill Physician Practices to furnish information to insurance carriers concerning my illness and/or treatment and hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Pat/Resp Party Signature: _____ Date: _____

Dr. Becker * Dr. Blessey * Dr. Yarbrough

Meeta Nicholas, CRNP * Kim Ochab, CRNP

Patient Information

1. Our primary care providers do not treat chronic pain that requires narcotics.
2. Our primary care providers do not prescribe tranquilizers, including Xanax, Valium, Ativan, etc.
3. Our primary care providers do not prescribe stimulants, including Ritalin, Adderall, Adipex, Amphetamines
4. Refills will not be called in after office hours and do require a recent visit by one of our providers.
5. Medication for chronic medical conditions will be prescribed for 1, 3 or 6 months.

Patient Signature:_____

Date:_____

Springhill Medical Center
3719 Dauphin Street
Mobile, AL 36608

Notice of Privacy Practices Acknowledgement Revised: 9/2013

I acknowledge that Springhill Medical Center has made their Notice of Privacy Practices available to me.

Signature of Patient or Patient's Representative

Relationship to Patient

Date

Witness

SPRINGHILL PHYSICIAN PRACTICES

3715 Dauphin Street, Suite 7A * 1924-K Dauphin Island Parkway
Phone (251) 410-4001 * Fax (251) 410-4002

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Last Physical Exam: _____

Reason for today's visit:

_____

_____

Primary Care Provider:

_____

Are you allergic to any Medications/Substances: Yes / No If so, please list below:

Medication/Substance: Reaction:

_____

_____

_____

_____

Please list any and all medications/supplements that you are currently taking: Please include Dosage & Frequency:

Medication/Supplement: Dosage: Frequency:

_____

_____

_____

_____

Name of Preferred Pharmacy: _____

Address: Phone Number:

_____

Patient Name:_____

HEALTH HISTORY

Below, please check any SYMPTOMS you currently have or have had in the past year:

GENERAL
___Chills
___Depression
___Dizziness
___Fainting
___Fever
___Forgetfulness
___Headache
___Loss of sleep
___Nervousness
___Night Sweats
___Numbness
___Weight Loss
___Other _____

GASTROINTESTINAL
___Poor Appetite
___Bloating
___Bowel Changes
___Constipation
___Diarrhea
___Excessive Hunger
___Excessive Thirst
___Gas
___Hemorrhoids
___Indigestion
___Nausea
___Rectal Bleeding
___Stomach Pain
___Vomiting
___Colonoscopy Performed
___Other_____

EYE/EAR/NOSE/THROAT
___Bleeding Gums
___Blurred Vision
___Crossed Eyes
___Difficulty Swallowing
___Double Vision
___Earache
___Ear Discharge
___Hay Fever
___Hoarseness
___Hearing Loss
___Nose Bleeds
___Persistent Cough
___Ringing in Ears
___Sinus Problems
___Vision Flashes or Halos
___Other_____

MUSCLE/JOINT/BONE
___Arms
___Feet
___Hands
___Hips
___Legs
___Lower Back
___Neck
___Shoulders
___Upper Back
___Other_____

CARDIOVASCULAR
___Chest Pain
___High Blood Pressure
___Irregular Heartbeat
___Low Blood Pressure
___Poor Circulation
___Rapid Heartbeat
___Swelling of Ankles
___Varicose Veins
___Heart Catheterization Performed
___Other_____

GENITO-URINARY
___Blood in Urine
___Difficulty Urinating
___Frequent Urination
___Kidney Stones
___Lack of Bladder Control
___Painful Urination
___Other_____

SKIN
___Bruise Easily
___Hives
___Itching
___Change in Moles
___Rash
___Scars
___Sores That Will Not Heal
___Other_____

OTHER
_____
_____
_____

Patient Name:_____

HEALTH HISTORY CONTINUED

Please check CONDITIONS you currently have or have had in the past:

___AIDS
___Alcoholism
___Anemia
___Anorexia
___Appendicitis
___Arthritis
___Asthma
___Bleeding Disorder
___Breast Lump
___Bronchitis
___Bulimia
___Cancer
___Cataracts
___Chemical Dependency
___Chicken Pox
___Diabetes
___Emphysema
___Epilepsy
___Glaucoma
___Goiter
___Gonorrhea
___Gout
___Heart Disease
___Hepatitis
___Hernia
___High Blood Pressure
___High Cholesterol
___HIV Positive
___Kidney Disease
___Liver Disease
___Measles
___Migraine Headaches
___Miscarriage
___Mononucleosis
___Multiple Sclerosis
___Mumps
___Pacemaker Placement
___Pneumonia
___Prostate Problems
___Psychiatric Care
___Rheumatic Fever
___Scarlet Fever
___Stroke
___Suicide Attempt
___Thyroid Problems
___Tonsillitis
___Tuberculosis
___Typhoid Fever
___Ulcers
___Vaginal Infections
___Weight Problems
___Other_____

MEN ONLY:

___Breast Lump
___Erection Difficulties
___Lump in Testicles
___Penis Discharge
___Prostate Problems
___Sore on Penis
___Other_____

WOMEN ONLY:

___Abnormal Pap Smear
___Bleeding Between Periods
___Breast Lump
___Extreme Menstrual Pain
___Hot Flashes
___Nipple Discharge
___Painful Intercourse
___Vaginal Discharge
___Other_____

PREGNANCY HISTORY:

Year	Sex	Complications
____	___	_____
____	___	_____
____	___	_____
____	___	_____
____	___	_____
____	___	_____

Date of Last Mammogram_____
Date of Last Menstrual Period_____
Date of Last Pap Smear_____

SOCIAL HISTORY

Please check which substances you use:

___Caffeine
___Tobacco Packs per day ____
___Previous Smoker
___Alcohol- Socially
___Alcohol-Daily
___Drugs_____
___Other_____

FAMILY HISTORY

Please check if your Blood Relatives have had any of the following:

CONDITION	RELATIONSHIP TO YOU
___Arthritis/Gout	_____
___Asthma, Hay Fever	_____
___Cancer	_____
___Chemical Dependency	_____
___Diabetes	_____
___Heart Disease	_____
___High Blood Pressure	_____
___Kidney Disease	_____
___Seizures	_____
___Stroke	_____
___Tuberculosis	_____
___Other	_____

Patient Name:_____

SURGICAL HISTORY

Please list all surgeries, procedures and hospitalizations:

Date	Hospital	Surgery/Procedure/Reason for Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY DOCTOR OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

Patient Signature:_____

Date:_____