

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) are not authorized 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:

Please list names of others in the household:

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

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

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: Cigarettes Previously, but quit (date) _____ Currently smoke _____ packs/day
 Never 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?

	Father	Mother	Brother	Sister	Paternal Grand-father	Paternal Grand-mother	Maternal Grand-father	Maternal Grand-mother
Please check:								
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (list type):								
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:								
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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 _____

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