FAMILY MEDICAL CENTER

Name *(Last, First, M.I.):*				**DOB:**
Home Phone		**Cell Phone**		**Work**
Mailing Address				
City	**State**		**Zip code**	
Sex M F	**Date of Birth**		**Age**	**SSN**
Spouse/Parent				
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed				
Email:		**Preferred Method of Contact**		

Race:	**Ethnicity**
Primary Insurance Company Name	
Policy Holder's Name	**Relationship to Patient**
DOB	**SSN**
ID#	**Group#**
Secondary Insurance Company Name	
Policy Holder's Name	**Relationship to Patient**
DOB	**SSN**
ID#	**Group#**
Emergency Contact Name	**Emergency Contact Phone**

Signature: _____ By signing you agree to allow your provider to access your prescription history.

Advanced Directive: All adults in health care settings in the state of Florida have the right to an "advance directive". This is a written or oral statement made and witnessed in advance of a serious illness or injury, stating how medical decisions will be made. An advance directive enables you to state your choice or name someone to make your choice for you, if you should become unable to make decision about your medical treatment. An advance directive can enable you to make decisions. Do you have a Living Will? _____ Yes _____ No (If yes, please provide this office with a copy. If no, and you would like a living will, we have one available.)

Signature: _____ Date _____

I authorize the release of medical information necessary to obtain payment of medical benefits from my health insurance company. I also authorize my insurance company to pay Family Medical Center any medical benefits due for services rendered. I understand that I am responsible to pay deductibles, co-pay and any other charges not paid by my insurance company. **CO-PAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF YOUR OFFICE VISIT.** Our policy is that payment is expected in full at the time services are rendered, unless other financial arrangements are made **in advance.** If you participate with one of our contracted insurance programs, we will bill your insurance company. Verification of your insurance, deductible, and co-payment in advance of your office visit will be necessary. To the best of my knowledge the above information is correct. I understand and agree to comply with the practice's financial policy.

Signature: _____ Date _____

Print Name: _____

FAMILY MEDICAL CENTER

Medical History

Name _____ Age _____ Date _____

ALLERGIES	FAMILY HISTORY				
		Father	Mother	Siblings	Children
	Heart Disease				
	High Blood Pressure				
	Stroke				
Family History	Cancer				
Father: Living or Deceased Age	Glaucoma				
Mother: Living or Deceased Age	Diabetes				
Siblings: Living or Deceased Age	Epilepsy/ Seizures				
	Bleeding Disorder				
	Kidney Disease				
	Thyroid Disease				
	Mental Illness				
	Arthritis				

Hospitalization or Surgery

Reason	Date	Reason	Date

Past Medical History

☐ Allergies	☐ Gallbladder Disease	☐ Nervousness	**Date of Last Immunization**
☐ Anemia	☐ Gout	☐ Pneumonia	☐ Flu Vaccine
☐ Arthritis	☐ Headache/Migraines	☐ Prostate Disease	☐ Tetanus
☐ Bowel Irregularity	☐ Heart Murmur	☐ Rheumatic Fever	☐ Pneumonia
☐ Bronchitis	☐ Heart Palpitations	☐ Seizure Disorder	☐ MMR
☐ Cancer	☐ Hepatitis	☐ Sexual/Menstrual Dysfunction	☐ PPD
☐ Chest Pain	☐ High Cholesterol	☐ Shortness of breath	☐ Other
☐ Depression	☐ High Triglycerides	☐ Ulcer	
☐ Diabetes	☐ Hypertension	☐ Other	

Habits/Risk Factors

Smoke Yes No Ever Smoked Yes No

Packs Daily? _____ How Long? _____

Alcohol Yes No Type? _____

Street Drugs? Yes No Type? _____

Contact with blood/bodily fluids at work? Yes No

Coffee: Cups Daily? _____ Other Caffeine? _____
No

Diet: _____ Fat Intake _____ Salt Intake

Exercise? Yes No Type? _____ Amount? _____

Sleep Patterns? _____

Advance Directive

Advance Directive? Yes No

(*If yes, please provide a copy*)

Women Only

Menstruation: First Age: _____

Flow is: Light Moderate Heavy

Days between Period: _____

Days Period Lasts: _____

Date of last Period: _____

Pregnant? Yes No Planning Yes

Total # of pregnancies: _____

Full term? Yes No

Number of living children: _____

Age of youngest? _____

Type of Birth Control? _____

Gynecologist name _____

Date of last Pap Smear? _____

Date of last Breast Exam? _____

Date of last Mammogram? _____