Patient Information:

Referred By: (If Applicable)____________________

Patient's Name:____________________
First Middle Last Preferred

Address:____________________
Number and Street Apt/Lot City State Zip

SSN:__________ Date of Birth:__________ Marital Status:__________

Male or Female (Circle one) Race:__________ Language:__________ Email:__________

Main Phone:__________ 2nd Phone:__________ 3rd Phone: __________

Best Method of Contact: Phone or Email (Circle one) Do you have insurance: Yes or No (Circle one) __________

Employer:__________ Occupation:__________ School:__________

Poilcyholder's Name:____________________
First Middle Last

Address:____________________
Number and Street Apt/Lot City State Zip

Relationship to Patient:__________ SSN:__________ Date of Birth:__________

Male or Female (Circle one) Race:__________ Language:__________ Email:__________

Employer:__________ Occupation:__________

Payment Information:

Individual Responsible of Payment:____________________ __________
First Middle Last

Address:____________________
Number and Street Apt/Lot City State Zip

Relationship to Patient:__________ SSN:__________ Date of Birth:__________

Best Method of Contact: Phone or Mail or Email (Circle one) Email Address:__________

Main Phone:__________ 2nd Phone:__________ 3rd Phone: __________

Patient's Contacts:

Pharmacy:__________ Location:__________

Emergency Contact 1:____________________
Name Relationship Main Phone 2nd Phone

Emergency Contact 2:____________________
Name Relationship Main Phone 2nd Phone

All professional services rendered are the financial responsibility of the patient. Payment is expected upon the provision of services. For insured patients, we are pleased to assist in the filing of your insurance claims. I hereby consent to treatment provided by Winnsboro Medical Clinic.

By signing below, I hereby consent to my insurance carrier releasing all necessary information to Winnsboro Medical Clinic regarding the status of my claims. Further, I hereby authorize Winnsboro Medical Clinic to furnish information to my insurance carrier concerning my medical history, illness, and treatments. Further, I authorize my insurance carrier to pay directly to Winnsboro Medical Clinic all benefits to which I and/or my dependents may be eligible for the provision of healthcare services.

I have READ, UNDERSTAND, and AGREE to the provisions above

SIGNATURE:____________________ Date:__________

Medical History

Review of System Form

Date: ________ Name: ______________________ Date of Birth: ____________

Married: ________ Single: ________ Divorced: ________ Widowed: ________ Occupation: ____________

Number of Children: ________ Tobacco Use: ________ Frequency: ________

Date Quit Tobacco Use: ________ Alcohol Use: ________ Frequency: ________

Caffeine (Coffee, Tea , Cola) Per Day: ________

Past Illnesses of Yourself and Family

	You	Family		You	Family		You	Family
Alcoholism			High Blood Pressure			Stroke		
Anemia			Kidney Disease			Suicide Attempt		
Asthma			Liver Disease			Thyroid Disease		
Cancer/Tumor			Hepatitis			Tuberculosis, TB		
Diabetes			Lung Disease			Ulcer In GI Tract		
Drug Abuse			Mental Illness			Veneral Disease		
Depression			Osteoarthritis			High Cholesterol		
Epilepsy/Seizures			Osteoporosis			HIV/Immune DX		
Glaucoma			Phlebitis			Other:__________		
Heart Disease			Rheumatic Arthritis			Other:__________		

PAST SURGICAL HISTORY: (Please Include Dates): ______________________________

____

____

Review of Systems - Please Check Each Item "Yes" or "No" As They Relate To Your Health:

Constitutional	Yes	No
Weight Loss		
Fatigue		
Fever		
Eyes	**Yes**	**No**
Glasses/Contacts		
Eye Pain		
Double Vison		
Cataracts		
Ear/Nose/Throat	**Yes**	**No**
Difficulty Hearing		
Ringing In Ears		
Vertigo		
Sinus Trouble		
Nasal Stuffiness		
Frequent Sore Throat		
Cardiovascular	**Yes**	**No**
Murmur		
Chest Pain		
Palpitations		
Dizziness		
Fainting Spells		
Shortness of Breath		
Difficulty Lying Flat		
Swelling Ankles		
Endocrine:	**Yes**	**No**
Loss of Hair		
Heat/Cold Intolerance		

Respiratory	Yes	No
Cough		
Coughing Blood		
Wheezing		
Chills		
Gastrointestinal	**Yes**	**No**
Heartburn/Reflux		
Nausea/Vomiting		
Constipation		
Change in BMs		
Diarrhea		
Jaundice		
Abdominal Pain		
Black or Bloody BM		
Gastrourinary	**Yes**	**No**
Burning/Frequency		
Nighttime		
Blood in Urine		
Erectile Dysfunction		
Abnormal Discharge		
Bladder Leakage		
Allergic/Immunologic	**Yes**	**No**
Hives/Eczema		
Hay Fever		
Psychiatric	**Yes**	**No**
Anxiety/Depression		
Mood Swings		
Difficulty Sleeping		

Hematology/Lymph	Yes	No
Easy Bruising		
Gums Bleed Easy		
Enlarged Glands		
Musculoskeletal	**Yes**	**No**
Joint Pain/Swelling		
Stiffness		
Muscle Pain		
Back Pain		
Skin	**Yes**	**No**
Rash/Sores		
Lesions		
Itching/Burning		
Neurological	**Yes**	**No**
Loss of Strength		
Numbness		
Headaches		
Tremors		
Memory Loss		

Females ONLY: Date of Last Mammogram: ____________ Normal ________ Abnormal ________

Date of Last Pap: ____________ Normal ________ Abnormal ________ Age Onset Periods: ________

Age Onset Menopause: ________ Regular Periods: ________ Number of Pregnancies: ________

Signature/Reviewing Physician: ______________________________

READ AND COMPLETE BACK

NEW PATIENT - PLEASE COMPLETE THE FOLLOWING

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS, VITAMINS, AND SUPPLIMENTS

Medicine Name	How Taken?	Who Prescribes?	Need Prescription?
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No
			Yes No

PREFERRED PHARMACY: ____________ **LOCATION:** ____________

PREVIOUS HEALTH CARE PROVIDERS IN THE PAST FIVE YEARS:

Name:	City/State	Problem Cared For:	Still Seeing?	Referral?
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No
			Yes No	Yes No

ALLERGIC AND ADVERSE REACTIONS TO MEDICATION:

Medication Name:	Adverse Reaction:

Additional Information:

Last Mammogram? ____________ Where? ____________ Last Pap? ____________

GYN? ____________ WMC To Perform Future Paps? Yes No

Date of Last Colonoscopy? ____________ Normal? Yes No Dr? ____________

Date of Next Colonoscopy? ____________ Approximate Date of Last Bloodwork? ____________

Date of Last Rectal Exam? ____________

Vaccination Dates:

Tetanus? ____________ Pneumonia? ____________ Flu? ____________

Zostavax? ____________ Hepatitis B Series? ____________

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review a patient's "medication history." A medication history is a list of prescription and over-the-counter medications that we or other physicians have prescribed for the patient. This list is collected from a variety of sources, including the pharmacy and the health insurer.

An accurate medication history is very important in helping us properly treat our patients and in avoiding potentially dangerous drug interactions.

By signing this consent form, you are giving us (WMC) permission to collect, and giving your pharmacy and your health insurer permission to disclose information about prescription and over-the-counter medications that have been filled at any pharmacy or covered by any health insurer. This includes but is not limited to prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become of the patient's medical record.

This medication history should be helpful; however, it may unfortunately not be completely accurate. Some pharmacies may choose not to make a drug history available to us. The drug history from a health insurer might not include drugs that were purchased without using health insurance. A medication history may not include all of the over-the-counter medications, supplements, and herbal remedies a patient may be currently taking. It is still, however, very important for us to take the time to discuss everything the patient is taking, and for you to point out to us any errors or omissions in the medication history.

I give permission for – Winnsboro Medical Clinic-to obtain my medication history from all applicable pharmacies, health insurer(s), and other healthcare providers.

____

Patient

____

Printed Name

____

Date

WINNSBORO MEDICAL CLINIC

By signing this document, I agree that I have received and had an opportunity to review this ***Notice of Privacy Practice***.

______________________	______________________
Patient's Name	Date of Birth
______________________	______________________
Patient/Guardian Signature	Date

The following is a list of all persons who may request or have access to my ***Personal Health Information***.

Name	Relationship
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

This authorization will remain in force until I, ________________________________ request in writing that a change be made.