Primary Care Doctors name:					PCP Ph:
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑Single ❑ Mar ❑ Div ❑Sep ❑ Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):		Birth date: / /	Age: Sex: ❑ M ❑ F
Race:	Ethnicity:	Religion Preference:			
Email:		Language:		Interpreter Needed: ❑ Yes ❑ No	
Street address: Apt #		Social Security:		Home ph: ( )	
P.O. Box:	City:	State:	ZIP Code:	Cell ph: ( ) Work ph: ( )	
Employment Status: ❑ Full Time ❑ Part Time ❑Unemployed ❑ Student ❑ Other:		Employer:		Employer ph: ( )	
How did you hear about us:					
INSURANCE INFORMATION					
(Please give your insurance card & ID to the receptionist)					
Person responsible for bill: **(If 18 or older put SELF)**		Birth date: / /	Address (if different from patient):	Home ph: ( ) Cell ph: ( )	
Occupation:	Employer:	Employer address:		Employer ph: ( )	

PRIMARY INSURANCE

Name of primary insurance:_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy#:_____

Co-payment: $ _____

Patient's relationship to subscriber:

❑ Self ❑ Child ❑ Spouse ❑ Other

SECONDARY INSURANCE

Name of secondary insurance :_____

Subscriber's name:_____

Subscriber's S.S.:_____

Birth date:_____

Group:_____

Policy #:_____

Patient's relationship to subscriber:

❑ Self ❑ Child ❑ Spouse ❑ Other

IN CASE OF EMERGENCY		
Name of local friend or relative:	Relationship to patient:	Home ph: ( ) Work ph: ( ) Cell ph: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims. I acknowledge receipt for the notice of privacy policies and practices of this clinic.

_____ _____

Patient/Guardian signature **Date**

Authorization to Release Protected Health Information to Delegate

Patient Name (print):_____ **DOB:** _____

By signing this form, I authorize CHI St. Luke's Medical Group to disclose protected health information such as office consultations, labs, radiology and other test results to the person or people listed below. I understand that it is my responsibility to update this release form if necessary and/or remove delegates.

CHI St. Luke's Medical Group May Release my protected health information to the following people:

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

Preferred Contact Method

CHI St. Luke's Medical Group will often contact patients for appointment reminders and testing results. Please indicate the method in which our office may contact you and or leave messages on authorized phone numbers.

_____Initial Primary Contact Number _____ cell/home/work/other

_____Initial Secondary Contact Number _____ cell/home/work/other

_____Initial I do not wish to be contacted in any other manner than a direct conversation, no messages may be left.

Patient /Guardian Signature_____

Authorization and Assignment Acknowledgement Form

My signature certifies I have read and understand the content of the Auth. & Assignment Acknowledgement doocument.

Patient / Guardian Signature_____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ **Date:** _____

Patient / Guardian Signature

_____ _____

Relationship (if not the patient) **SLMG Witness**

NAME:_____

What's the reason for your visit today? _____

How long has this bothered you? _____ Date of injury (if applicable): _____

Pharmacy name and location: _____

Shoe size: _____ Height: _____ Weight: _____

Medical History

Do you have any problems with the following (please circle all that apply):

Alcoholism	Blood disorders	Gout	Liver disease	Sleep apnea
Allergies	Breathing problems	Heart disease	Musculoskeletal	Stomach/bowel
Arthritis (specify)	Circulation problems	Heart murmur	Neurological (specify)	Thyroid (specify)
_____	Depression/anxiety/ mental illness	High blood pressure	_____	_____
Asthma		High cholesterol	Skin disorders (specify)	Other (specify)
Blood clot/DVT/PE	Diabetes	Kidney disease	_____	_____

Are you pregnant? Yes No

Prior surgeries: _____

Allergies: _____

Family History of (circle and family member): Diabetes, High blood pressure, Stroke, Cancer, Bleeding disorders

Social History

Do you smoke? _____ Packs per day: _____ Quit? (please write year) _____

Any alcohol use? _____ Amount: _____

Occupation: _____

How many hours per day do you spend on your feet? _____

Medications

Name	Dosage	Number of times/day	Notes

MEDICATION REFILL POLICY

For your health and safety, it is required that certain medications be monitored with periodic evaluation of blood testing (for possible side effects) At this office, we try our best to ensure that your medications are uninterrupted.

As necessary, laboratory testing will be ordered prior to your next office visit. It is YOUR RESPONSIBILITY to get this testing done before your return visit.

(5-10 days prior to appointment date)

At your visit you will be given enough prescriptions to last until your next scheduled visit. In case of a missed or rescheduled appointment, Please contact our office, Not your pharmacy to request a medicine refill.

Be prepared to provide your pharmacy's name and phone number

We can only refill a prescription for a short period of time until your next office visit, provided appropriate monitoring test(s) have been performed.

Please allow our office up to 48 hours to get in touch with your pharmacy.

If appointments are routinely missed, rescheduled or cancelled, our office

CANNOT refill your prescriptions.

Please feel free to speak with any of our staff members if you have questions.

NAME:_____

SIGNATURE: _____

DATE: _____