GRAND RIVER MEDICAL CLINIC

PATIENT NAME:_____ Birth date:_____
ADDRESS:_____ Social Security #:_____
Street, Apt. No.
City:_____ State:_____ Zip:_____
Home Phone:(___)_____ County:_____ Sex:_____ Race:_____ Religion:_____
Cell Phone:_____

MAIDEN NAME:_____ (Single patients or male patients give mother's maiden name)
Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

PATIENT EMPLOYER
NAME:_____ ADDRESS:_____
Employer Phone: (____)_____ _____
Street, Appt.. No. City, State, Zip
Occupation:_____Employment Status: Full Time____ Part Time ____ Retired ____ Unemployed ____

PERSON TO NOTIFY
NAME:_____ ADDRESS:_____
Phone: (____)_____ Relationship:_____

NEXT OF KIN (If same as person to notify leave blank)
NAME:_____ ADDRESS:_____
Phone: (____)_____ Relationship:_____

GUARANTOR (Who is responsible for bill: Self or (Who is bringing pt in today if minor)NOT INSURANCE)
NAME:_____ ADDRESS:_____
Phone: (____)_____ S.S. Number:_____

GUARANTOR EMPLOYER
NAME:_____ ADDRESS:_____
EMPLOYMENT STATUS:_____ OCCUPATION_____ EMPLOYER PHONE: (___)_____

IF PATIENT IS A MINOR WE NEED BOTH PARENTS EMPLOYMENT INFORMATION. THIS SECTION IS FOR THE PARENT THAT IS NOT LISTED IN THE GUARANTOR INFORMATION ABOVE.
NAME: _____SS#_____DATE OF BIRTH_____
ADDRESS_____RELATIONSHIP TO PATIENT_____
EMPLOYER ADDRESS _____PHONE:_____
EMPLOYMENT STATUS_____

Primary Care Physician:_____ Reason for Visit:_____

READ AND SIGN
I hereby authorize payment directly to my physician's office, of any Insurance coverage for treatment rendered, and authorize them to release any information necessary to process these insurance claims.
I understand that I am fully responsible for all social services and charges, including any balance due after payment of insurance, and that insurance coverage does not necessarily pay all charges.
I also understand that doctor and office fees are due and payable when services are rendered.
I, the undersigned, authorize treatment by the physician of this office.

SIGNATURE:_____
(If Minor, Parent or Guardian Signature)

DATE:_____

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PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

Name:_____ Today's Date:_____

Birth Date:_____ Age:_____ Sex:_____

Past Health History: Please list all previous hospitalizations, surgeries, serious injuries, and blood transfusions. Include year or age.

_____

_____

_____

_____

_____

Your Medical History: Please circle Yes or No if you have any of the following medical problems?

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes	No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Bleeding Problems	Yes	No	HIV/AIDS	Yes	No	Other Problems		

Allergies:_____

Current Medications: Please List all medications which you are currently taking. (Be sure to include over the counter medications)

Name of Medication	Strength	How Often	Date Began	Date Last Taken

Social History:

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Tobacco Use: ☐Never ☐Quit/when_____ ☐Current smoker/packs per day_____

Alcohol Use: ☐Never ☐Rarely ☐Weekly ☐Daily ☐How much/type?_____

Drug Use: ☐Never ☐Rarely ☐Weekly ☐Daily ☐How much?_____

Occupation:_____

How much coffee, tea, and/or soda do you drink in a day? _____

What type of exercise do yo practice?_____

What activities do yo do for fun?_____

Former schooling:_____

Occupation:_____

GRAND RIVER MEDICAL CLINIC

Patient Name:_____ Date of Birth_____

REVIEW OF SYSTEMS (ROS) Please circle Yes or No if you have any of the following problems?

☐ **Constitutional**			☐ **Ears/Nose/Mouth/Throat**			☐ **Eyes**		
Good General Health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent Weight Change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats, fevers	Yes	No	Nose Bleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No	Glaucoma	Yes	No
☐ **Cardiovascular**			☐ **Respiratory**			☐ **Gastrointestinal**		
Chest Pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitation	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart Trouble	Yes	No	Wheezing/Asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No
						Reflux	Yes	No
☐ **Musculoskeletal**			☐ **Neurological**			☐ **Integumentary (Skin/Breast)**		
Muscle pain or cramps	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/seizures	Yes	No	Breast lump	Yes	No
Trouble walking	Yes	No	Numbness/tingling	Yes	No	Breast pain or discharge	Yes	No
☐ **Endocrine**			☐ **Hematologic/Lymphatic**			☐ **Genitourinary - Male Only**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Blood in urine	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Kidney Stones	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Sexual problems	Yes	No
						Testicle pain	Yes	No
☐ **Genitourinary - Female Only**			☐ **Psychiatric**					
Blood in urine	Yes	No	Insomnia	Yes	No			
Kidney Stones	Yes	No	Confusion/memory loss	Yes	No			
Sexual problems	Yes	No	Depression	Yes	No			
Menstrual problems	Yes	No						

Family Health History: To your knowledge, do any of your immediate family members have the following? If yes WHO?

Heart Disease _____ Stroke_____

Diabetes_____ Lung Disease_____

Cancer /Type _____

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete.

Signed:_____ Date:_____

NOTES:

PHYSICIAN STATEMENT: I have reviewed the questionnaire.

Signed:_____ Date:_____

Signed:_____ Date:_____

Signed:_____ Date:_____

Signed:_____ Date:_____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT FORM

I have received or I have been provided the opportunity to receive a copy of the Notice of Privacy Practices that explains when, where, and why my confidential information may be used or shared. I acknowledge that Fitzgibbon Hospital and its affiliates, the physicians, the nurses, and other Fitzgibbon Hospital staff my use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Fitzgibbon Hospital's operations and responsibilities.

Patient Name _____ Relationship to Patient _____

Signature _____
Patient (or Designated Representative)

Date _____ Witness _____

In order to help control the cost of billing, we request payment be made for all office services at the conclusion of your visit unless other arrangements have been made prior to services being rendered.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature _____

Date _____