Patient Medical Form

General / Family Practice

Please print clearly and complete all sections.

SECTION 1: PATIENT DEMOGRAPHICS

Full Legal Name (Last, First, Middle): ____________________

Preferred Name: ____________________ Date of Birth (MM/DD/YYYY): ____________________

Sex: M / F / Other ____________ Age: ____________ Marital Status: ____________

Street Address: ____________________

City: ____________ State: ____________ ZIP Code: ____________

Phone (Primary): ____________________ Phone (Alternate): ____________________

Email Address: ____________________ Preferred Contact Method: ____________________

Emergency Contact Name: ____________________ Relationship: ____________________

Emergency Contact Phone: ____________________

SECTION 2: INSURANCE INFORMATION

Primary Insurance Company: ____________________ Policy/Group #: ____________________

Subscriber Name: ____________________ Subscriber DOB: ____________________

Relationship to Patient: ____________________ Employer: ____________________

Secondary Insurance (if any): ____________________ Policy/Group #: ____________________

SECTION 3: MEDICAL HISTORY

Check all conditions that apply to you now or in the past:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Asthma/COPD

☐ Stroke ☐ Cancer (type: ____) ☐ Thyroid Disorder ☐ Kidney Disease

☐ Seizures/Epilepsy ☐ Liver Disease ☐ Arthritis ☐ Depression/Anxiety

☐ Bleeding Disorder ☐ Anemia ☐ GERD/Acid Reflux ☐ Sleep Apnea

Other Conditions: ____________________

Previous Surgeries / Hospitalizations (include year): ____________________

____

SECTION 4: CURRENT MEDICATIONS

List all prescription medications, over-the-counter drugs, vitamins, and supplements:

Medication Name	Dose / Strength	Frequency	Reason

SECTION 5: ALLERGIES

☐ No Known Allergies

If you have allergies, list each one with the reaction you experienced:

Allergy (Drug / Food / Environmental)	Reaction

SECTION 6: REASON FOR TODAY'S VISIT

Primary Reason / Chief Complaint: ______________________________

____

When did symptoms begin? ______________________________

Pain Level (circle one): 0 1 2 3 4 5 6 7 8 9 10

SECTION 7: CONSENT & SIGNATURE

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I authorize this practice to release medical information as necessary for treatment, payment, or healthcare operations. I understand that I am financially responsible for any charges not covered by my insurance.

Patient Signature: ______________________________ Date: ______________________________

Printed Name: ______________________________ Relationship (if signed by representative): ____________