PATIENT INFORMATION FORM

CRANMORE HEALTH PARTNERS
Primary, Pain, and Urgent Care

Date: _____

Patient's Name: _____ DOB: _____
Last First Middle

Maiden Name: _____

Patient's Address: _____
Street or P.O. Box

City/State/Zip: _____

Sex: ☐ M ☐ F Marital Status: ☐ S ☐ M ☐ D ☐ W

Home Phone: _____ Cell Phone: _____

Email address: _____

Employer: _____ Work Phone: _____

Address: _____ City/State/Zip: _____

GUARANTOR INFORMATION *(Person responsible if the insurance doesn't pay all)*

☐ NOT Employed ☐ Self-Employed

Guarantor's Name: _____

Relation to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

Guarantor's Address: _____
Street or P.O. Box Phone Number

Guarantor's Employer: _____

Work Number: _____ Occupation: _____ ☐ Full Time ☐ Part Time

EMERGENCY CONTACT

Name: _____ Phone Number: _____

INSURANCE INFORMATION

☐ No Insurance

Name of Insurance: _____ Policy Number: _____

Group Number: _____ Group Name: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Policy Holder Social Security: _____

A COPY OF THE PATIENT'S INSURANCE CARD AND PICTURE ID ARE REQUIRED.

PATIENT HEALTH HISTORY FORM

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Do you have any health concerns? If yes, please list : _____

_____

_____

_____

_____

Please Check Any Of The Following Problems That Apply To You: ____ **NO PROBLEMS**

GENERAL
- ☐ Fever
- ☐ Sweats

ALLERGY
- ☐ Seasonal
- ☐ Symptoms
- ☐ Sneezing
- ☐ Itchy eyes
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Postnasal drip

CARDIOVASCULAR
- ☐ Chest pain or pressure
- ☐ Ankle swelling
- ☐ Palpitations

ENDOCRINE
- ☐ Excessive urination
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat intolerance
- ☐ Cold intolerance

EYES
- ☐ Blurred vision
- ☐ Changing vision

GENITOURINARY
- ☐ Urinary frequency
- ☐ Burning with urination
- ☐ Blood in urine
- ☐ Awaken at night to urinate

HEMATOLOGIC
- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Hard to stop bleeding

MENTAL HEALTH
- ☐ Insomnia
- ☐ Guilt
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal thoughts

EAR/NOSE/THROAT
- ☐ Ear pain
- ☐ Runny nose
- ☐ Sneezing
- ☐ Postnasal drip

NUTRITION
- ☐ On a special diet
- ☐ Weight gain or loss greater than 10 pounds

GI
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Blood in stool

MUSCULOSKELETAL
- ☐ Joint swelling
- ☐ Joint pains
- ☐ Muscle pains

RESPIRATORY
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Shortness of breath with exertion

SKIN
- ☐ Rash
- ☐ Changing mole
- ☐ Itching
- ☐ Slow healing wounds

NEUROLOGIC
- ☐ Numbness
- ☐ Tingling
- ☐ Headaches
- ☐ Weakness

DAILY LIVING
- ☐ Violence in your home
- ☐ Problems with sex
- ☐ Changes in functional ability
- ☐ Exposure to sexually transmitted disease
- ☐ Changes in eating habits
- ☐ Changes in sleeping habits
- ☐ Problems urinating

SOCIAL HABITS:

Have you ever smoked? ☐ Yes ☐ No Use: ☐ Current ☐ Past

Type: ☐ Cigarettes ☐ Cigars ☐ Oral ☐ Pipe ☐ Other Number per Day: _____ Number of Years: _____

Have you ever drank alcohol? ☐ Yes ☐ No Use: ☐ Current ☐ Past Type: ☐ Beer ☐ Wine ☐ Liquor

Amount: ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week ☐ daily
☐ Several times per day

Have you ever used illegal drugs? ☐ Yes ☐ No Use: ☐ Current ☐ Past

Type: ☐ Amphetamines ☐ Inhalants ☐ Glues ☐ Solvents ☐ Cocaine ☐ Marijuana ☐ Ecstasy ☐ Hallucinogen
☐ Methamphetamines ☐ LSD ☐ Prescription Medications ☐ Heroin ☐ Other _____

Amount: ☐ 1-2 times per year ☐ 1-2 times per month ☐ 1-2 times per week ☐ 3-5 times per week ☐ daily
☐ Several times per day

How many glasses/cups of caffeine do you drink daily? _____

Do you wear seat belts? ☐ Always ☐ Usually ☐ Sometimes ☐ Never

What is your occupation? _____

Are you sexually active? ☐ Yes ☐ No If so, ☐ 1 partner ☐ Multiple partners ☐ With women ☐ With men

Do you exercise? ☐ Yes ☐ No Duration (Average Number of Minutes) _____ per session?

How many times per week? ☐ 1-2 times ☐ 2-3 times ☐ 3-4 times ☐ 4-5 times ☐ 5-6 times ☐ daily

Type of exercise: ☐ Walking ☐ Aerobics ☐ Running ☐ Swimming ☐ Weight Lifting ☐ Yoga ☐ Other: _____

FAMILY HISTORY: Has anyone in your family had any of the following? (Check appropriate box)

ILLNESS	Mother If deceased, enter age at death_____	Father If deceased, enter age at death_____	Brothers/Sisters If deceased, enter age at death_____	Paternal Grandparent	Maternal Grandparent
High Blood Pressure					
Heart Attack/ Heart Surgery					
Diabetes					
Stroke					
Seizures					
COPD					
Kidney Disease					
Cancer (Type/Location)					
Osteoporosis					
Thyroid Problems					
Mental Illness					
Rheumatoid Arthritis					
Lupus					

PAST MEDICAL HISTORY: Check conditions that doctors have followed you for in the past:

☐ High blood pressure/hypertension ☐ High Cholesterol ☐ Liver Disease ☐ Diabetes ("sugar") ☐ Asthma
☐ Thyroid Problems ☐ Kidney Disease ☐ Heart Attack/By-pass Surgery ☐ COPD ☐ Ulcers ☐ Stroke
☐ Seasonal Allergies/Hay fever ☐ Heart Failure ☐ Heart Murmur ☐ Irregular Heartbeat ☐ Migraines
☐ GI Bleed ☐ Seizures/Epilepsy ☐ Stomach Problems ☐ Intestinal Problems ☐ Reflux Disease ☐ Glaucoma
☐ Psychiatric Illness ☐ Arthritis ☐ Abnormal PAP
☐ Other:_____
☐ Cancer: Type & Location _____

List any hospitalizations: _____

_____

_____

List any surgeries, dates, and who performed them:_____

_____

_____

SCREENINGS AND IMMUNIZATIONS:

SCREENINGS	DATE	IMMUNIZATIONS	DATE RECEIVED
Mammogram		Tetanus	
Pap Smear		Pneumovax	
Colonoscopy		Shingles	
Bone Density		Hepatitis B	
PSA		PPD (TB skin test)	
Vision Screening		Fluvax	

FEMALE ONLY: How often do you examine your breasts? _____ Do you see an OB/GYN doctor? ☐ Yes ☐ No
# of pregnancies_____ # of live births_____

MALE ONLY: Do you do self-testicular exams? ☐ Yes ☐ No Do you have any problems with erections? ☐ Yes ☐ No

List any Allergies:_____

_____

_____

List ALL CURRENT MEDICATIONS (including over the counter, vitamins, herbal, and health food preparations):

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Are Blood Transfusions Acceptable to Patient in Emergencies? ☐ Yes ☐ No

How many people live with you? _____

Do you have: ☐ Advanced Directive ☐ Living Will ☐ Healthcare Power of Attorney

How do you learn best? ☐ Read it ☐ Tell me ☐ Show me Highest level of education completed? _____

Have you fallen in the past 30 days? ☐ Yes ☐ No

Do you feel safe at home ☐ Yes ☐ No

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ASSIGNMENT OF MEDICARE AND/OR MEDICAID BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled to Cranmore Health Partners including Medicare and Medicaid.

Medicare patients will be asked to review and sign an Advance Beneficiary Notice (ABN) for all services, which may be deemed not medically necessary.

Signature of Insured **Date**

ASSIGNMENT OF BENEFITS

I hereby assign all medical and / or surgical benefits to which I am entitled to Cranmore Health Partners including private insurance and any/ all other third party coverage

If we do not participate with your insurance plan, we request that your charges for office visits be paid at the end of each visit

Signature of Insured **Date**

PAYMENT GUARANTEE

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, the undersigned individually obligates himself/herself to pay the account of Cranmore Health Partners in accordance with the regular rates and terms of the practice. Furthermore, the undersigned is obligated to make weekly or monthly payments, if requested. The account be turned over to a collection agency or an attorney for collection, the undersigned shall pay all collection fees and reasonable attorney's fees.

I understand that I am responsible to Cranmore Health Partners for charges incurred by me and not paid for by Medicare, Medicaid, or third party benefits.

INSURANCE COLLECTIONS

In order for Cranmore Health Partners to file your insurance for you, a copy of your insurance card (front and back) is required.

Cranmore Health Partners will send billing form to your insurer. If your employer/insurance carrier requires other claim forms, these must be submitted completely filled out, and signed. (You are always responsible for the entire amount of the charges.) All applicable coinsurance and deductibles are due upon Check Out.
Payment options available through Rectangle Health ☐ Yes ☐ No

I acknowledge that I have read or had read to me the entire above document. I understand it and I agree that Cranmore Health Partners may bill me and that I will pay for non-covered services or services determined to be not medically necessary.

Signature of Insured **Date**