Forest Family Care, INC.

Adult Initial Patient Information Date:_____

Provider you prefer to see: _____ **Provider Last Seen:**_____

Patient Name:_____
(Please Print) Last First Middle

Home Address:_____City:_____State:_____Zip:_____

Phone: Home ( )_____Work: ( )_____ Cell: ( )_____

Social Security # Patient __ __ __- __ __- __ __ __ __ Age__ __ __ Birth Date: ____/_____/_____

Sex: _____Male _____Female _____Transgender

Marital Status: ____Single ____Married ____Widowed ____Divorced _____Separated

Race: ____White _____Hispanic _____Black _____Other

Language: _____English _____Hispanic _____Other

Email:_____ Employer:_____

Primary Insurance Co._____ Insurance ID #_____

Group # _____ Policy Holder SS # __ __ __- __ __- __ __ __ __

Secondary Insurance Co. _____ Insurance ID #_____

Group # _____ Policy Holder SS # __ __ __- __ __- __ __ __ __

Emergency Contact: _____ Phone: ( )_____

Relation to patient: _____

Preferred Pharmacy: _____ Phone: ( )_____

I understand the FINANCIAL POLICY OF THIS OFFICE IS AS FOLLOWS: Payment to be made prior to service. Co-pays', deductible and non-covered services are to be paid at time of service. I understand that my signature is valid for the purpose of filing me or my child's insurance and I authorize payment of benefits to Forest Family Care, INC.

PLEASE GIVE YOUR CURRENT INSURANCE CARD(S) TO RECEPTIONIST TO COPY. THANK YOU.

Patient 's Signature: _____ Date:_____

Forest Family Care, INC.

1785 W. Lee Hwy
Wytheville, VA 24382

(276) 228-6499 Phone
(276) 228-6145 Fax

Authorization for the Release of Protected Health Information

Patients Name:_____ DOB: _____

Address: _____City:_____ Zip:_____

Social Security Number:_____

I hereby authorize: _____
(One Physician From Whom you are Requesting Records) (One physician per page-Make Copies if needed)

To Provide Confidential Information Contained Within My Medical Record: Forest Family Care

Information to be released should include:

☐ Complete health record ☐ Office Notes ☐ Discharge Summary ☐ History & Physical Exam
☐ Consulting Reports ☐ Progress Notes ☐ Laboratory Test Results ☐ X-ray reports ☐ Itemized Bill ☐ X-ray Films/Images ☐ Immunization Record ☐ Demographic/Insurance Information

The purpose of this request is:

☐ Treatment and/or Consultation ☐ At the request of the patient ☐ Other:_____

The following Dates of Service Should be Included in this request:

☐ All dates of service ☐ From (Date):_____ To (Date): _____

I, the undersigned, have read and authorize the staff on the disclosing facility named to disclose information as herein contained. I understand the information disclosed by this authorization may be subject to re-disclose by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1988. The facility, its employees, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified about under "Purpose of Request". I can inspect or copy the protected health information to be used or disclosed. Except to the extent that action has been taking in compliance with this request, this authorization may be revoked by me at any time, by submitting a notice in writing to the Privacy Office at Forest Family Care. Unless revoked, this authorization will expire in six months unless otherwise specified, or in the event of

_____.

Signature _____ **Date:** _____

Initial _____ I acknowledge and hereby consent to such, that the released information may contain alcohol abuse, psychiatric, sexually transmitted disease, Hepatitis B or C, HIV testing, HIV results or AIDS information.

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Adult History

Patient Name: _____ DOB: _____ AGE:_____

To help us meet all of your healthcare needs, please fill out this form completely. This is a confidential record of your medical history and will be kept in this office.

Today's date:_____ When was your last physical exam? _____

Have you seen any of the providers in our office in the past three years? ____Yes _____NO
Our providers: Susan Moore, CFNP, Jill Snider, CFNP, Etthan Miller, CFNP, Jan Rasnake,CFNP, Tara Parks, CFNP & Dr. Griffin

1. Current Medications/Vitamins/Supplements

Drug Name:	Dose:	How Often:

- Have you been seen in the past for chronic pain management? Circle one: Yes or NO
- Current medication you are presently out of? (Please provide medications in space below)

_____

_____

2. PAST Medical History:

	YES	NO
Abnormal Weight Gain		
Abnormal Weight Loss		
Excessive Fatigue		
Insomnia		
Anemia		
Cancer		
Tumor		
Glasses/Contacts		

	YES	NO
Glaucoma		
Cataracts		
Hearing Loss		
Ear Problems		
Ringing in Ear		
Dentures		
Dental Problems		
Heart Attack		

	YES	NO
High Blood Pressure		
Breathing Problems		
Frequent Bronchitis		
Emphysema		
Pneumonia		
Asthma		
Heartburn		
Ulcer disease		
Gallbladder Disease		
Blood in Stool		
Hepatitis		
Diarrhea, Constipation, or other changes in bowel habits		
Hemorrhoids		
Abdominal Pain		
Colon Polyp		
Gout		
Broken Bones		
Rash		
Hives		
Seizure		
TIA		
Stroke		
Numbness		
Weakness		

Memory Loss		
	YES	NO
Headaches		
Depression		
Anxiety/Panic Attacks		
Suicide Attempt		
Physical Abuse		
Sores in Mouth		
Angina		
Frequent Chest Pain		
Irregular Heartbeat		
Heart Murmur		
Rheumatic Fever		
High Cholesterol		
Heart Failure		
Urinary Frequency		
Bladder Infections		
Prostate Problems		
Urinary Incontinence		
Kidney Problems		
Arthritis or joint pain		
Sexual Abuse		
Mental Illness		
Diabetes		
Thyroid Disease		
Abnormal Pap Smear		
Breast Lump		

3. CURRENT Medical Issues:

____Fever
____Weight Gain
____Weight Loss
____Fatigue
____Insomnia
____ Vision Changes
____Problems Swallowing
____Trouble Hearing
____Chest pain/pressure
____Swelling
____Palpitations/Racing Heartbeat
____Shortness of Breath
____Painful Breathing
____Cough
____Wheezing
____Vomiting
____Acid Reflux/Heartburn
____Nausea
____Rectal Bleeding/blood in stool
____Constipation
____Diarrhea

____Painful urination
____Increased urinary frequency
____Urinary urgency
____Urinary incontinence
____Back Pain
____Joint Swelling
____Joint redness
____Rash
____Concerning or changing skin lesion
____Headache
____Memory Loss
____Weakness
____Anxiety
____Depression
____High blood sugar
____Low blood sugar
____High blood pressure
____Low blood pressure
Other:
_____
_____

4. Please list any food or drug ALLERGIES you have had:

Name of drug/food:	**Reaction:**	**Date of Occurrence:**

5. Please list any HOSPITALIZATIONS you have had in the past 3 years:

Location:	Reason:	Year:

6. Please check or list all of the SURGERIES you have had:

	Type of Surgery	Year:
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery	
	Hemorrhoids	
	Hernia	

	Type of Surgery:	Year:
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery	
	Other Specify	

7. For WOMEN:

Last menstrual period	/ /
Last pap smear	/ /
Last mammogram	/ /
Last bone density	/ /

# of days in cycle	
# of days in flow	
Are you menopausal	YES or NO
Age at onset of menopause	

Age of first period	

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

8. Please list any SPECIALTY providers you currently see:

Specialty:	Providers Name:

9. Have any of your FAMILY members had any of the following?

Family Member	Diabetes	Hypertension	Heart Disease	Stoke	Mental Illness	Cancer	Unknown
Daughter							
Father							
Son							
Mother							
Paternal Grandfather							
Paternal Grandmother							
Maternal Grandfather							
Maternal Grandmother							
Sibling(s)							

10. Social History

- Do you smoke currently? YES or NO
  - If so, how much? _____ cig/day _____# of years smoking
- If no, did you smoke in the past? YES or NO
- Are you exposed to smoke? YES or NO
- Any other tobacco use? YES or NO
  - If so, what type? _____
- Do you drink caffeine? YES or NO
- Do you drink alcohol? YES or NO
  - If so, how much? _____ drinks/day
- Have you ever used drugs? YES or NO
- Do you exercise? YES or NO
- Do you wear a seatbelt? YES or NO
- Do you use assistive medical devices? YES or NO
- How many members are in your household? _____
- Is there concern for your safety (emotional, physical, or sexual abuse)? YES or NO

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Consent to Obtain Prescription History

This consent form authorizes Forest Family Care to obtain and review my prescription history. Detailed prescription history provides your physician with information about medications being prescribed by other providers involved in your medical care. This information will improve the accuracy of our medication list in your medical chart and decrease any adverse drug reactions or inaccurate medication information such as medication names or dosages.

By signing this consent form you agree that Forest Family Care can request and use your prescription medication history from other healthcare providers, pharmacies, and benefit payors (such as your insurance company) for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Forest Family Care to request, view, and use my external prescription history for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Patient Name (printed):_____

Patient Date of birth:_____

Patient Signature:_____

Date:_____

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I hereby declare that the information provided is true and accurate. I also understand that any willful dishonesty may render for refusal of this application or dismissal from the practice. 30 days from being accepted to our office or upon your initial face to face, if any of the above information is false or inaccurate this will result in dismissal from the practice.

Signature: _____ Date: _____