

Insurance Information: Please fill out the below information completely. Failure to complete the following questions could result in your claim being denied by your insurance carrier(s). We will also need a copy of your insurance card(s) and a valid identification.

Primary Insurance Co _____ Patient's Policy Number _____

Policy Holder's Name _____ Group # _____ Relation to Patient _____

Policy Holder's Address _____ Telephone Number _____

Policy Holder's Date of Birth _____ Social Sec # _____ Sex M F

Employer/Business policy is with _____ (if applicable)

Secondary Insurance Co _____ Patient's Policy Number _____

Policy Holder's Name _____ Group # _____ Relation to Patient _____

Policy Holder's Address _____ Telephone Number _____

Policy Holder's Date of Birth _____ Social Sec # _____ Sex M F

Employer/Business policy is with _____ (if applicable)

I would like the medical record of today's visit faxed to my primary care physician. (Please check one)

Yes _____ (or) **No** _____

Preferred method of contact for results: Phone _____ **Email** _____ **Mail** _____

Please complete if patient is a minor or a student

Mothers Name: _____ Date of Birth: _____

Address: _____ Social Sec # _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Fathers Name: _____ Date of Birth _____

Address: _____ Social Sec # _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Nearest Friend or Relative

Emergency Contact Name: _____ Relationship _____ Daytime Phone: _____

Consent for Treatment: I hereby authorize City of Bryan Employee Health Center to examine, treat and perform diagnostic tests and office procedures that the physician deems necessary.

Privacy Practices: City of Bryan Employee Health Center is required by law to maintain the privacy of a patient's protected health information. In addition we are required by law to provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. You must list any restrictions on the release of your protected health information below.

I have read and agree to the Financial Agreement and Consent for Treatment as listed above. My signature below indicates that I have also received a copy of the City of Bryan Employee Health Center Notice of Privacy Practices and I have indicated any restrictions of my Protected Health Information below. Scanned signatures suffice as original.

I am 18 years old or older and authorize release of this information to _____ () Yes () No

Please check one: () No restrictions () Restrictions _____

Signature _____ **Date** _____
Patient or Person completing form and relationship

Medical Information

Current Medication

Are you taking ANY kind of medication now? (This includes prescription, over-the-counter or herbal medications)

NO YES If yes, please list below *include dosages*.

Medication Name	Dosage	How often taken
EXAMPLE. Glucatorl	5mg	TWO

Medication Allergies

Are you allergic to any form of medication?

NO YES If yes, please complete the form below.

Name of Medication	Type of reaction (nausea, hives, etc)

Have you ever been hospitalized or had surgery?

NO YES. If yes, list all reasons and the date and/or your age at the time.

Reason For Hospitalization	Date of Hospitalization
Type of Operation	Date of Operation

Family History

You Relative

[] Seizures/Convulsions

[] Headaches

[] Hearing loss

[] Lung Problem

[] Liver Trouble or Hepatitis

You Relative

[] Asthma

[] Heart Disease

[] Arthritis

[] High Blood Pressure

[] Kidney Disorder

You Relative

[] Colon Cancer

[] Breast Cancer

[] Anxiety

[] Depression

[] Other Mental Health Disorder

Social History

Have you ever used tobacco in any form? No Yes Total Years: _____ Average amount per day: _____

Do you consume alcohol? No Yes Average weekly consumption: _____ Alcohol problem in past? No Yes

Do you use drugs recreationally? No Yes Types used: _____ Last Used: _____

Please list any other medical information you feel is important:
