INDIAN RIVER PRIMARY CARE

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NEW PATIENT INFORMATION

I have compared all of these data points to a current continuity of care report presented to me on this date and all of the data is already accurate and up to date to the best of my knowledge.

DEMOGRAPHIC DETAILS

Name ______________________________

SSN ______________________ DOB ______________________

HOME # ______________________ WORK # ______________________

CELL # ______________________ Email ______________________

Address ______________________________

____

City ______________________ State ______ ZipCode ______________

Occupation ______________________________

CURRENT MEDICATIONS

Description	Dosage	How Often

DRUG ALLERGIES

Description

FAMILY HISTORY	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy / Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

PAST SURGERY HISTORY

Patient Name: Date of Birth:

MEDICAL HISTORY

☐ Abdominal Pain - Chronic	☐ Emphysema	☐ Mental Illness	☐ Vision - Failing
☐ ADD / ADHD	☐ Epilepsy	☐ Migraine Headaches	☐ Weight Loss - Recent
☐ Alcoholism	☐ Eczema	☐ Miscarriage (s)	☐ Weight Gain - Recent
☐ Allergies	☐ Eye Infections - Frequent	☐ Mononucleosis	
☐ Anemia	☐ Fatigue	☐ Multiple Sclerosis	
☐ Ankles - Swollen	☐ Fibromyalgia	☐ Mumps	
☐ Angina (Chest Pain)	☐ Foot Pain (Cold or Numbness)	☐ Nose Bleeds - Frequent	
☐ Anorexia	☐ Fractures	☐ Osteoporosis	
☐ Anxiety	☐ Frequent Cold / Flu	☐ Pertussis	
☐ Appendicitis	☐ Gall Bladder - Trouble	☐ Pneumonia	
☐ Arthritis	☐ Gastritis	☐ Polio	
☐ Asthma	☐ Glaucoma	☐ Prostate Problems	
☐ Athlete's Foot	☐ Gonorrhea	☐ Psoriasis	
☐ Back Pain	☐ Gout	☐ Rheumatoid Arthritis	
☐ Bladder Infection	☐ Hair Loss	☐ Rubella	
☐ Bleeding Disorders	☐ Headaches - Frequent	☐ Sexual / Menstrual Dysfunction	
☐ Bone Fractures	☐ Heart Disease	☐ Sinusitis, Acute or Chronic	
☐ Bowel Habits - Changed	☐ Hear Murmur	☐ Sore Throat - Frequent	
☐ Breast Lumps / Cysts	☐ Hemorrhoids	☐ Stroke	
☐ Bronchitis - Chronic	☐ Hepatitis	☐ Swallowing Difficulty	
☐ Bulimia	☐ Hernia	☐ Tendonitis	
☐ Bursitis	☐ Herpes (Mouth)	☐ Tetanus	
☐ Cancer	☐ Herpes (Genital)	☐ Thyroid Problems	
☐ Cataracts	☐ High Blood Pressure	☐ Tonsillitis	
☐ Cavities (dental)	☐ High Cholesterol	☐ Tuberculosis	
☐ Chicken Pox	☐ Hyperglycemia (Glucose/Sugar Elevated)	☐ Tumors / Growths	
☐ Constipation	☐ Hypoglycemia (Glucose/Sugar - Low)	☐ Typhoid Fever	
☐ Convulsions / Seizures	☐ Indigestion or Heartburn	☐ Ulcers	
☐ Crohn's / Colitis	☐ Infections - Frequent	☐ Urethral Discharge	
☐ Depression	☐ Kidney Disease	☐ Urination	
☐ Diabetes (Insulin / Non-Insulin Dependent)	☐ Lactose Intolerance	Decrease in Force / Flow	
☐ Diarrhea	☐ Leg Pain - Walking	Painful	
☐ Diphtheria	☐ Liver Disease	Increase / Loss of Control	
☐ Diverticulosis	☐ Low Blood Pressure	Blood Present	
☐ Dizziness / Fainting	☐ Manic Depression	☐ Vaginal Infections	
☐ Ear Infections - Frequent	☐ Measles	☐ Varicose Veins	
☐ Ear - Ringing	☐ Menopause	☐ Venereal Disease	

FEMALES - PLEASE COMPLETE

	YES	NO
Pregnant	☐	☐
Planning Pregnancy	☐	☐

___ # Pregnancies ________ Live Births

___ Miscarriages ________ Abortions

Menstrual Flow

☐ Regular ☐ Pain/Cramps

☐ Irregular

___ Length of Cycles ________ Days of Flow

1st Day of Last period (Date) __________

Pain / Bleeding during or after intercourse ☐ ☐

Birth Control Method

____

____

Flushing / Menopause ☐ ☐

Date of Last Pap Test __________

☐ Normal

☐ Abnormal

Date of Last Mammogram __________

☐ Normal

☐ Abnormal

MALES - PLEASE COMPLETE

	YES	NO
Prostate Problems	☐	☐
Date - Last Prostate Exam	______	
Date - Last Prostate Blood Test	______	

ALL PATIENTS - PLEASE COMPLETE

	YES	NO
Ever had a Colonoscopy?	☐	☐
Date - Last Colonoscopy	______	
Doctor who performed it	______	

LIST OF OTHER PHYSICIANS WHO MAY BE TREATING YOU

____

____

____

____

____

____

____

____

Do you receive Narcotic prescriptions from any other physician? If yes, list the physician & medication.

____

____

____

HABITS

	YES	NO
Alcohol	☐	☐
How much/often		
Caffeine	☐	☐
How much/often		
Salt	☐	☐
How much/often		
Exercise	☐	☐
How much/often		
Sleep Trouble	☐	☐
How often		
Smoke	☐	☐
How much/often		

Name ____________________

Gender ☐ Male ☐ Female **D.O.B:**

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

Patient Employer Information

Employer ____________________

Telephone # ____________ Fax # ____________

Whom may we thank for referring you? ____________

In case of emergency, who should be notified? ____________

PRIMARY INSURANCE

Person Responsible for account ____________

Relationship to patient ____________ SSN ____________

DOB ____________

Insurance Company ____________

Subscriber Name ____________

Subscriber Relationship (self or spouse) ____________

Subscriber #/ Contract # ____________

Group # ____________

Subscriber DOB ____________ Subscriber SSN ____________

Prescription Plan ____________

Prescription ID # ____________

Telephone # ____________

ADDITIONAL INSURANCE (2ndary)

Is patient covered by an additional insurance policy? ☐ Yes ☐ No

Insurance Company ____________

Subscriber Name ____________

Subscriber Relationship (self or spouse) ____________

Subscriber #/ Contract # ____________

Group # ____________

Subscriber DOB ____________ Subscriber SSN ____________

Prescription Plan ____________

Prescription ID # ____________

Telephone # ____________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage (listed above), and assign directly to Indian River Primary Care, either Dr. Dalili or Dr. Lewis, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____________ ____________ ____________

Responsible Party Signature | Relationship | Date