Prime Care 12 Priority Care

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Patient Information

Last Name _____ First Name _____ MI _____

Gender ☐ M ☐ F SSN _____ DOB _____

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

Race ☐ White ☐ Hispanic ☐ African American ☐ Asian ☐ Native American ☐ Other

Mailing Address _____

City _____ State _____ Zip _____

Physical Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____

Email _____

Employer _____ Phone _____

Address _____ ST _____ Zip _____

Spouse _____ Phone _____

DOB _____ SSN _____

Employer _____ Phone _____

Living Will? Y ☐ N ☐ Medical POA? Y ☐ N ☐

Emergency Contact: Name _____

Relationship _____ Phone _____

General Health Review

Medical History:

Surgical History:

Medications:

Allergies:

Do you have any of the following? (check all that apply)

- ☐ Headaches
- ☐ Stomach Pain
- ☐ Chest pain
- ☐ Vision Problems
- ☐ Nausea
- ☐ Shortness of Breath
- ☐ Hearing Problems
- ☐ Vomiting
- ☐ Urinary Problems
- ☐ Dizziness
- ☐ Constipation
- ☐ Rashes
- ☐ Cough
- ☐ Diarrhea
- ☐ Swollen Joints
- ☐ Chronic Fatigue
- ☐ Difficulty Swallowing

Domestic Situation

Who do you live with? _____

Are there any substance abuse issues in the household? Y ☐ N ☐

If yes, please explain _____

Are you able to take care of yourself? Y ☐ N ☐

If not, please enter name of caregiver _____

Substance Use

Which of the following drugs or substances, if any, have you used in the **past**? Next to each drug or substance that you have used in the past, indicate if you used it occasionally (O), frequently (F), or continuously (C)

Alcohol _____ Heroin _____ Cocaine _____ Marijuana _____ Other _____

Amphetamines _____ Barbiturates _____ Other _____ Other _____

Are you **presently** using any of the drugs or substances listed below? Next to each drug or substance that you are currently using, indicate if you are using it occasionally (O), frequently (F), or continuously (C)

Alcohol _____ Heroin _____ Cocaine _____ Marijuana _____ Other _____

Amphetamines _____ Barbiturates Other Other

Do you presntly smode cigarettes or use tobacco in any form? Y ☐ N ☐

If not, did you ever smode cigarettes or use tobacco in any form? Y ☐ N ☐

How many packs do/did you smoke per day? _____ How many years? _____

Vaccines

Have you had any of the following vaccines? If so, please give dates received.

Flu Vaccine _____ Pneumonia _____ Shingles _____ COVID _____ Hepatitis _____

Miscellaneous

Have you had any of the following procedures? If so, please give dates last performed.

Colonoscopy _____ Mammogram _____ Dialated Eye Exam _____

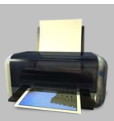
Authorizations

I authorize Prime Care 12 Priority Health to provide medical care as may be determined to be in the best interest of the patient/minor who is a member of my immediate family. This will continue to be effective until revoked in writing by me. I also authorize payment directly to Prime Care 12 Priority Health. I realize that I am responsible to pay for any balance due. In the event I do not have insurance, I understand that all charges incurred are due at the time of serivce, unless other arrangements have been made prior to treatment.

Authorized signature of patient/responsible party Typing your name will serve as your electronic signature	Date

Please either print this form and bring it with you to your appointment or you can email it ahead of time.

Email Form



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