



New Patient Information

Patient Name:

SSN:

Address: Street/PO Box:

Apt/Suite:

City:

State:

Zip Code:

Phone Number (for lab results/confidential items):

Cell Phone Number (please check 'Same' if as above): Same

Date of Birth:

Sex: F M

Marital Status: S M D W

Policy Holder/Guarantor Information (Complete this section *only if different* from patient information)

Policy Holder/Guarantor Name:

SSN:

Relationship to patient (please check): Self Spouse Parent Date of Birth:

Address (please check 'Same' if as above): Same Street/PO Box:

Apt/Suite:

City:

State:

Zip Code:

Phone Number (for lab results/confidential items; please check 'Same' if as above): Same

Cell Phone Number (please circle 'Same' if as above) : Same

Emergency Contact

Name:

Relationship:

Phone Number:

Work Phone:

Primary Physician

Name:

Phone:

Is this visit related to a Workers' Compensation or No Fault claim? (please check) YES NO

I am responsible for all charges regardless if covered by insurance. I authorize my signature's use on insurance submissions.

Signature of Patient or Guarantor: _____ Date:

Today's Main Illness/Injury:

- How did you hear of us? (please check one) Billboard Doctor Referral Friend
- Internet Mailer Newspaper Phone Book Relative Work Other

Medical Information Sheet



Patient Name

Employer (or retired or N/A)

Current or Prior Job Title (or not working or homemaker)

Today's Main Problem (include location on body if applicable)

If cut, please write year of last Tetanus

When did Main Problem start? (date and time if applicable)

Medical Conditions (i.e. Diabetes, Hypertension, Thyroid Condition, Cancer) or check none: **None**

Current medications (including dosages and over-the-counter medications) or check none: **None**

Surgeries or check none: **None**

Family Medical History or check none: **None**

Father

Mother

Sibling

Other

Tobacco (please check) **Never** **Cigarettes** **Cigars** **Chew or Snuff** **Other** Quit in

If currently smoking cigarettes, packs per day (please check) **< ½** **<1** **1** **1 ½** **2 or more**

Alcoholic drinks per day including beer and wine (please check) **Never** **<1** **1-2** **2-3** **>3**

Street/Unprescribed Drugs (if none, please check) **None** Please list

Allergies or intolerances to medications (and your reaction to them) or check none: **None**

For Females: Menses (First Date of Last Menstrual Period)

Pregnant (please check)? **Yes** **No** **Unsure**

Surya Immediate Medical Care, P.C.
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PATIENT PRIVACY NOTICE

Surya Immediate Medical Care, P.C. is obligated under HIPAA to protect the privacy of your Protected Health Information ("PHI") and to provide you with a notice of its privacy practice (the "Privacy Notice").

I have been informed of HIPAA regulation policy and procedures related to this at Surya Immediate Medical Care, P.C. and acknowledge that I have received a copy of the Practice's Privacy Notice.

Patient Signature

Date

(Optional) I designate _____, to act as my Designated Individual. I am aware that I can change my designated individual at any time.