Southern NH Internal Medicine Associates

PATIENT INFORMATION

Name: _____ Date of Birth: _____
(First) (Last)

Sex: F M Marital Status: S M D Other:_____

Mailing Address: _____ City: _____ ST: ____Zip Code: _____

Street Address:_____City: _____ ST: ____Zip Code: _____

Home Phone: _____ Phone #2: _____ E-mail: _____

INSURANCE INFORMATION

Insurance Co. : _____ ID #:_____ Group#:_____

Subscriber Name: _____ Date of Birth: _____ Relationship: _____

EMERGENCY CONTACT/NEXT OF KIN

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

PATIENT RESULTS CALLBACK AUTHORIZATION INFORMATION:

We recognize the importance of receiving a call back in a timely manner. In order for us to effectively and efficiently deliver information to you when you are unavailable, we request your permission to give information to an authorized designee. Please check the applicable boxes below and list the name of a person or persons that we may speak with if necessary.

Please list any exceptions or instructions: _____

_____

I authorize Southern NH Internal Medicine to leave any message on my:

☐ Answering machine at home ☐ Cell phone voice mail
☐ Answering machine at work ☐ All

I authorize Southern NH Internal Medicine to leave a message with or <u>speak to, those contacts listed below, regarding any</u> information that needs to be relayed to me.

Name: _____ _____ _____
(Print Name) (Relationship) (phone #)

Name: _____ _____ _____
(Print Name) (Relationship) (phone #)

Name: _____ _____ _____
(Print Name) (Relationship) (phone #)

☐ I do not wish to have a contact listed to speak to regarding any information that needs to be relayed to me.

This authorization remains in effect unless otherwise revoked or revised by the patient or guardian.

All professional services rendered are charged to the patient. Patients are responsible for providing the correct insurance information at the time of service. We will complete the necessary forms to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. I hereby authorize SOUTHERN NH INTERNAL MEDICINE to furnish information to insurance carriers and I authorize insurance benefits to be made either to me or on my behalf to SOUTHERN NH INTERNAL MEDICINE.

I acknowledge that the <u>Patient Privacy Notice</u> (HIPAA) has been offered to me and my questions answered.

_____ _____ _____
Printed Name Patient/Guarantor Signature Date

Revised 8/2017

Southern NH
Internal Medicine
Associates

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth:_____

1. Illnesses, medical conditions or diagnoses (include year):

_____
_____
_____

2. Allergies, including Medication Allergies:

_____
_____
_____

3. FAMILY HISTORY: (indicate yes or no and whom)

Cancer: _____

Diabetes: _____

Heart Attack: _____

Hypertension: _____

Past History:

_____
_____
_____

4. SOCIAL HISTORY:

Marital Status?	
Number in household?	
Highest level of education?	
Occupation?	
How many alcoholic drinks per week?	
Tobacco Use	
Other Substance Use?	
Do you exercise? If so, how often, what activity?	

(Continue on other side)

Southern NH
Internal Medicine
Associates

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth:_____

5. MEDICATIONS:
   a. Prescribed(included oxygen, CPAP, insulin, and inhalers):

_____
_____
_____

   b. Over the counter:

_____
_____
_____

6. Pregnancies? (If applicable):

_____
_____

7. Please list past surgeries/hospitalizations (include year and hospital):

_____
_____
_____

8. Health Maintenance(if applicable):

Vaccine	**Date/location**	**Screening**	**Date/location**
Tetanus		Colonoscopy	
Pneumonia		Mammogram	
Shingles		Bone Density	
Hepatatis B		Pap Smear	
Hepatitis C			

What other Doctors do you see regularly?

_____
_____
_____