St. Landry Family Healthcare

PATIENT DEMOGRAPHIC INFORMATION

Elliot Myers, APRN, FNP-C

PATIENT INFORMATION

Last Name | First Name | MI

□Male □Female | □Single □Married □Widowed □Divorced

Date of Birth | Social Security Number | Gender | Marital Status

□White □African American □American Indian □Asian □Decline □Other:

Race

Home Phone | Cell Phone | Work Phone | Email Address

Mailing Address | City | State | Zip

Physical Address (if different from mailing address) | City | State | Zip

Physician/Specialist you are currently seeing | Preferred Pharmacy | Pharmacy Phone

EMERGENCY CONTACT INFORMATION (Please put Parent/Guardian's name if patient is 17 or younger)

Contact Name | Relationship to Patient

Home Phone | Cell Phone

INSURANCE INFORMATION

■ **Primary Insurance**

Subscriber Last Name | Subscriber First Name | Subscriber MI

Subscriber Date of Birth | Subscriber Social Security Number

Relationship to Patient

Policy Number | Group Number

■ **Secondary Insurance**

Subscriber Last Name | Subscriber First Name | Subscriber MI

Subscriber Date of Birth | Subscriber Social Security Number

Relationship to Patient

Policy Number | Group Number

MAY WE DISCUSS YOUR PERSONAL HEALTH INFORMATION WITH ANYONE? (Please list the name and number of anyone you would like information released to).

Name | Phone | Relationship to Patient

Name | Phone | Relationship to Patient

I □accept □decline being added to the patient portal which will allow me to receive and access my health information. By signing below, I fully understand all of the above information. I have taken the time to read the above information and wholly affirm its contents.

Our clinic will charge a nominal fee of twenty dollars for administrative services (such as completing FMLA or disability forms) to cover our staff time devoted to these services.

Patient/Custodian Signature | Relationship to Patient | Date

PATIENT DEMOGRAPHIC INFORMATION (Cont'd.)

MEDICAL HISTORY

Closest Relative | Relationship to Patient | Phone

Family Physician | Address | Phone

Who referred you to our office?

Occupation | Employer

Please check if you now have or previously have had any of the following:

□ Heart Disease	□ Low Blood Pressure	□ Psychiatric Treatment	□ Arthritis
□ Heart Attack	□ Bleeding Disorder	□ Immune System Problems	□ Anemia
□ Chest Pain (Angina)	□ Liver Disease	□ Fainting	□ Asthma
□ Heart Murmur	□ Hepatitis	□ Convulsions	□ Glaucoma
□ Congenital Heart Defect	□ Jaundice	□ Seizures	□ Thyroidism
□ Rheumatic Fever	□ Stomach Ulcer	□ Allergies	□ Kidney Failure
□ Rheumatic Heart Disease	□ Tuberculosis	□ Diabetes	□ Cancer
□ High Blood Pressure	□ Shortness of Breath	□ Sinusitis	□ Artificial Limbs

List any allergies:

Have you had any serious illness, operation, or been hospitalized in the past 5 years?

If so, explain briefly.

Are you currently under the care of a doctor for any condition? (List)

Have you ever used or do you use any street drugs? (List)

Have you ever smoked, dipped or chewed tobacco? How often? How much/many daily?

Do you drink alcoholic beverages? How often? What is your drink of choice?

Do you have any disease, condition, or problems not listed above that you think I should know about?

If so, explain briefly.

Do you have any medical issues that you wish to discuss privately with your doctor?

What kind of problems are you having today?

FEMALE – Are you pregnant or nursing? Due date: Obstetrician:

Are you taking birth control pills? Last menstrual cycle:

FAMILY HISTORY

List any illness in the immediate family:

I have read and answered the above information truthfully and to the best of my knowledge.

Patient/Custodian Signature Date