

GRAYHAWK FAMILY PRACTICE

Patient Name: _____ Date form filled out: _____

**NEW PATIENTS: PLEASE FILL OUT FORM IN ITS ENTIRETY.
CURRENT PATIENTS: ONLY FILL OUT WHAT NEEDS TO BE UPDATED.
THANK YOU!**

Emergency Contacts and Authorized Persons

Name	Relationship	Phone #	*Emergency Contact	Permission to discuss financial information (monthly payments)	Permission to make, cancel & reschedule appointments on your behalf	Authorized to <u>obtain medical information & speak to our office</u> regarding your medical care
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

***At least one person must be listed above for an emergency contact.**

Preferred Pharmacy: _____ Major cross streets: _____

Additional Pharmacy: _____ Major cross streets: _____
(For patients who live in the local area and another state)

Name of previous physician and phone number if known: _____

Medical Insurance Company: _____ Claims Zip Code (Usually on back of card) _____

Policy # or Employee #: _____ Group Number: _____

Deductible: Yes No If yes, what is your deductible: _____ Appx. Amount you have met to-date: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

How did you hear about us? _____

Patient or Guardian Signature: _____ Relationship (If applicable): _____

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Patient Name: _____ Date form filled out: _____

Allergies/reaction: _____

Past surgeries and hospital stays (use second page for additional space):

Type of surgery or reason for hospital stay:	Appx date (month and year is okay)

Current medications taking, prescribed, over the counter and vitamins (use second page for additional space):

Name of medication:	Current dose:	Frequency taken:	Reason for taking:

Medical diagnoses (i.e. High blood Pressure, High Cholesterol etc. use second page for additional space):

Diagnoses:	Appx. Date diagnosed:

Family History (use second page for additional space):

Medical diagnosis:	Who in your family was diagnosed:

- Please provide immunization record if available. If not, are your immunizations up to date Yes No If no, what immunization do you think you need: _____
- Have you ever had an abnormal lab (for women this includes PAP's), study or test? date Yes No If yes, what was it and when was the appx. Date? _____

Patient or Guardian Signature: _____ Relationship (If applicable): _____

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Name of medication:	Current dose:	Frequency taken:	Reason for taking:

Medical diagnoses (i.e. High blood Pressure, High Cholesterol etc. use second page for additional space):

Diagnoses:	Appx. Date diagnosed:

Family History (use second page for additional space):

Medical diagnosis:	Who in your family was diagnosed:

PATIENT INITIALS