

becomes necessary to forward this account to collections, I agree to be responsible for any/all collection costs, attorney fees and/or court costs. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state. I realize that in extraordinary circumstances, some insurance companies will not pay for certain procedures (i.e. MRI's or Ultrasounds). I understand that my insurance is filed as a courtesy and I am responsible for the bill.

There is a \$50.00 fee for all no-call/no-show appointments or cancellations not made within 24 hours of scheduled appointment. All co-payments are due at the time of service.

Patient/Responsible Party Signature

Date

To help us expedite your first visit, please complete all the detailed information listed below to the best of your ability and return it to our office on/or before your appointment.

Name (First) (MI) (Last)

Date of Birth _____

Yes, if yes, please indicate below Allergic Reaction

ALLERGIES: Do you have any medication or food allergies?

List any food and/or medication allergies and indicate the side effect(s):

IMMUNIZATIONS: Please indicate date immunization received (mo/yr)

Influenza _____ Tetanus _____ Shingles _____ Pneumonia _____ HPV _____
Osteoporosis _____

PAST/PRESENT MEDICAL CONDITIONS

(Check all that apply)

Allergies
Anemia
Angina
Anxiety
Asthma
Atrial Fibrillation
Benign Prostate Hypertrophy
Blood Clots
Cancer (type) _____
COPD
Coronary Artery Disease
Crohn's Disease
Depression
Diabetes
GERD
Hearing Loss
Heart Attack
High Blood Pressure
High Cholesterol
Irritable Bowel Syndrome
Kidney Disease
Liver Disease
Migraines
Osteoarthritis

Seizure Disorder
Stroke
Thyroid Disease
Ulcer (Gastric)
Other

SURGICAL HISTORY

(Check all that apply & date/year completed)

Angioplasty
Angio w/stents
Appendectomy
Back Surgery
CABG
Carpal Tunnel Release
Cataract Surgery
Colon Surgery
Gallbladder Surgery
Gastric Bypass
Hernia Repair
Knee - Arthroscopy
Knee Replacement
LASIK
Pacemaker
Thyroidectomy

Tonsillectomy
GENDER Specific
 Breast Biopsy
 Breast Reduction
 Breast Augmentation
 Cesarean Section
 Hysterectomy

Mastectomy R / L
 Tubal Ligation
 D&C
 Prostate Biopsy
 Vasectomy
 Other_____

Who was your previous primary care physician?

Are you under the care of a specialist? Please list physician's name

Allergist: _____
 Cardiologist: _____
 Dermatologist: _____
 ENT: _____
 Endocrinologist: _____
 Gastroenterologist: _____
 Gynecologist: _____
 Neurologist: _____
 Neurosurgeon: _____

Oncologist: _____
 Orthopedic: _____
 Ophthalmologist: _____
 Pain Management: _____
 Podiatrist: _____
 Pulmonologist: _____
 Psychiatrist: _____
 Rheumatologist: _____
 Urologist: _____

DIAGNOSTIC TESTING. • If you have had testing, please indicate date and name of ordering physician

Bone Density: _____ Cardiac Cath: _____
 CT Scan: _____ Colonoscopy: _____
 Stress Test: _____ MRI: _____

FAMILY HISTORY (Please indicate family relations as listed below)

M-Mother	F-Father	B-Brother	S-Sister	G-Grandparent(s)	A-Aunt	U-Uncle
				High Blood Pressure		
				High Cholesterol		
				Irritable Bowel Syndrome		
				Mental Illness		
				Obesity		
				Osteoporosis		
				Rheumatoid Arthritis		
				Seizure Disorders		
				Vascular Disease		
				Other		

SOCIAL HISTORY

Do you use tobacco? Yes No If Yes, how long have you been a smoker? _____(years)
 Cigarette/Cigar/Tobacco/Snuff Pack (s) per day _____

