BLUE SPRINGS FAMILY CARE

NEW PATIENT INFORMATION SHEET

_____ _____ _____ _____
Last Name First Name MI Nickname

_____/_____/_____ Gender ☐M ☐F _____-_____-_____ ☐ Single ☐ Married
Date of Birth Social Security Number ☐ Divorced ☐ Widow

_____ _____ _____ _____
Address City State Zip

( ) _____-_____ ( ) _____-_____ _____ ( ) _____-_____
Home Phone Work Phone Ext Cell Phone

Daytime phone number that we can reach you at: ☐ Home ☐ Work ☐ Cell ☐ Other _____

May we leave personal health information – including appointments, test results and etc. – on your answering machine? Yes ☐ No ☐

Preferred contact method: ☐ Phone ☐ Mail ☐ Email/Patient Portal

Preferred reminder method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Mail ☐ Email/Patient Portal

_____ _____
Drivers License # / State E-Mail Address

_____ Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed
Patient's Employer ☐ Self Employed ☐ Retired ☐ Student ☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

Race: ☐ White ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Decline to answer

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino
☐ Other _____ ☐ Decline to answer

Spouse or Emergency Contact:

_____ _____ _____
Last Name First Name Relationship

_____ _____ _____ _____
Address City State Zip

( ) _____-_____ ( ) _____-_____ _____ ( ) _____-_____ _____
Home Phone Work Phone Ext Cell Phone Date of Birth

Whom may we speak with concerning your personal health information?
Name _____ Relationship _____
Are there any restrictions on what information we can give them? _____
_____

If we are unable to contact you, may we mail your personal health information to your home address?
Yes ☐ No ☐
Would you like information regarding an Advance Directive/Living Will?
Yes ☐ No ☐ Already have one on file ☐

BLUE SPRINGS FAMILY CARE, P.C. 104 N 7 HWY, SUITE B; BLUE SPRINGS, MO 64014 (816) 229-8880

Insurance Information

_____ ( ) _____-_____ $_____
Primary Insurance Company Claims Phone Office Visit Copay

_____ _____ _____ _____
Claims Address City State Zip

_____ _____ ____/____/_____
Policy/Identification Number Group Number Effective Date

_____ _____ _____ ____/____/_____ M/F
Policy Holder's Last Name First Name Relationship to Patient Date of Birth Gender

_____ _____ _____ _____ ( ) _____-_____
Policy Holder's Address City State Zip Home Phone

_____ _____ _____ ( ) _____-_____
Policy Holder's Employer Employment Address Position Work Phone

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_____ ( ) _____-_____ _____
Secondary Insurance Company Claims Phone Policy Holder's Employer

_____ _____ _____ _____
Claims Address City State Zip

_____ _____ ____/____/_____
Policy/Identification Number Group Number Effective Date

_____ _____ _____ ____/____/_____ M/F
Policy Holder's Last Name First Name Relationship to Patient Date of Birth Gender

_____ _____ _____ _____ ( ) _____-_____
Policy Holder's Address City State Zip Home Phone

_____ _____ _____ ( ) _____-_____
Policy Holder's Employer Employment Address Position Work Phone

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AUTHORIZATION AND CONSENT

I request that all payment of authorized Medicare/Insurance benefits on my behalf be paid to Blue Springs Family Care, P.C. for all services rendered to me. I authorize any holder of medical information about me be released to the Centers for Medicare and Medicaid Services or any insurance company listed above or their agents in order to determine any benefits payable for related services.

I authorize Blue Springs Family Care, P.C. to access my medication history and formulary information through a secure electronic connection.

I understand that services for which I am treated may or may not be covered by my insurance company and/or Medicare. I am aware that I can be billed and am responsible for any existing or remaining dollar balance after all mandatory adjustments have been made to my account.

The privacy polices of BSFC have been made available to me for my review.

BSFC gladly accepts your check as payment. However, in an effort not to inconvenience you in the unlikely event that these funds are dishonored, we reserve the right to collect them electronically for the face value of the check, plus a $25 processing fee.

_____ _____
Patient Signature Date

Printed Name _____ Patient Date of Birth _____/_____/_____

If parent or guardian please state relationship to patient _____

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HEALTH HISTORY - (Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

Symptoms – Check symptoms you currently have or have had in the past year.

General
- ☐Chills
- ☐Depression
- ☐Dizziness
- ☐Fainting
- ☐Fever
- ☐Forgetfulness
- ☐Headache
- ☐Loss of sleep
- ☐Loss of weight
- ☐Nervousness
- ☐Numbness
- ☐Sweats

Muscle/Joint/Bone

Pain, weakness, numbness in:
- ☐Arms ☐Hips
- ☐Back ☐Legs
- ☐Feet ☐Neck
- ☐Hands☐Shoulders

Genito-Urinary
- ☐Blood in urine
- ☐Frequent urination
- ☐Lack of bladder control
- ☐Painful urination

Gastrointestinal
- ☐Appetite poor
- ☐Bloating
- ☐Bowel Changes
- ☐Constipation
- ☐Diarrhea
- ☐Excessive hunger
- ☐Excessive thirst
- ☐Gas
- ☐Hemorrhoids
- ☐Indigestion
- ☐Nausea
- ☐Rectal bleeding
- ☐Stomach pain
- ☐Vomiting
- ☐Vomiting blood

Cardiovascular
- ☐Chest pain
- ☐High blood pressure
- ☐Irregular heart beat
- ☐Low blood pressure
- ☐Poor circulation
- ☐Rapid heart beat
- ☐Swelling of ankles
- ☐Varicose veins

Eye, Ear, Nose, Throat
- ☐Bleeding gums
- ☐Blurred Vision
- ☐Crossed Eyes
- ☐Difficulty swallowing
- ☐Double vision
- ☐Earache
- ☐Ear discharge
- ☐Hay fever
- ☐Hoarseness
- ☐Loss of hearing
- ☐Nosebleeds
- ☐Persistent cough
- ☐Ringing in ears
- ☐Sinus problems
- ☐Vision – Flashes
- ☐Vision – Halos

Skin
- ☐Bruise easily
- ☐Hives
- ☐Itching
- ☐Change in moles
- ☐Rash
- ☐Scars
- ☐Sore that won't heal

Men Only
- ☐Breast Lump
- ☐Erection difficulties
- ☐Lump in testicles
- ☐Penis discharge
- ☐Sore on penis
- ☐Other

Women Only
- ☐Abnormal Pap Smear
- ☐Bleeding between periods
- ☐Breast Lump
- ☐Extreme menstrual pain
- ☐Hot flashes
- ☐Nipple discharge
- ☐Painful intercourse
- ☐Vaginal discharge
- ☐Other

Date of last menstrual period _____

Date of last Pap Smear _____

Date of last mammogram?_____

Are you pregnant? _____

Number of children _____

Conditions – Check conditions you have had in the past.

- ☐Aids
- ☐Alcoholism
- ☐Anemia
- ☐Anorexia
- ☐Appendicitis
- ☐Arthritis
- ☐Asthma
- ☐Bleeding Disorders
- ☐Breast Lump
- ☐Bronchitis
- ☐Bulimia
- ☐Cancer
- ☐Cataracts
- ☐Chemical Dependency
- ☐Chicken Pox
- ☐Diabetes
- ☐Emphysema
- ☐Epilepsy
- ☐Glaucoma
- ☐Goiter
- ☐Gonorrhea
- ☐Gout
- ☐Heart Disease
- ☐Hepatitis
- ☐Hernia
- ☐Herpes
- ☐High Cholesterol
- ☐HIV Positive
- ☐Kidney Disease
- ☐Liver Disease
- ☐Measles
- ☐Migraine Headaches
- ☐Miscarriage
- ☐Mononucleosis
- ☐Multiple Sclerosis
- ☐Mumps
- ☐Pacemaker
- ☐Pneumonia
- ☐Polio
- ☐Prostate Problem
- ☐Psychiatric Care
- ☐Rheumatic Fever
- ☐Scarlet Fever
- ☐Stroke
- ☐Suicide Attempt
- ☐Thyroid Problems
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Typhoid Fever
- ☐Ulcers
- ☐Vaginal Infections
- ☐Venereal Disease

IMMUNIZATIONS – If disease, put "D" and year.

	Last year given		Last year given		Last year given
Tetanus	_____	Diphtheria	_____	Polio	_____
Measles	_____	Mumps	_____	Rubella	_____
Pertussis	_____	Chicken Pox	_____	☐ Immunization record requested	

Medications – List medications you are currently taking

Name _____ Dose _____ Name _____ Dose _____

Name _____ Dose _____ Name _____ Dose _____

Name _____ Dose _____ Name _____ Dose _____

Allergies – List all allergies to Medications or Substances

_____ _____

_____ _____

Pharmacy Name _____ Location _____ Phone _____

Have you ever had a blood transfusion? Yes No If yes, please give approximate dates:_____

Health Habits – Check which substances you use and describe how much you use.

☐ Caffeine _____ ☐ Drugs _____ ☐ Tobacco _____ ☐ Other _____

Occupational Concerns – Check if your work exposes you to the following:
☐ Stress ☐ Hazardous Substances ☐ Heavy Lifting ☐ Other _____

Hospitalizations / Surgical History / Serious Illness / Injuries / Pregnancies

Year	Condition		Outcome	If Hospitalized – Hospital Name

FAMILY HISTORY – Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives had any of the following diseases:

	Relationship to you		Relationship to you
☐ Arthritis, Gout	_____	☐ Heart Disease, Strokes	_____
☐ Asthma, Hay Fever	_____	☐ High Blood Pressure	_____
☐ Cancer / Location	_____	☐ Kidney Disease	_____
☐ Chemical Dependency	_____	☐ Tuberculosis	_____
☐ Diabetes	_____	☐ Other	_____

Patient Signature _____ **Date** _____

Printed Name _____ **Patient Date of Birth** _____/_____/_____

☐ Physician reviewed Date _____ Initials _____