NEW PATIENT INFORMATION

Please fill out completely

Last Name…………………………………………................First Name…………………………….........................M.I……………

Gender………………SSN……………………………….Marital Status…….…………………...Date of Birth……………………….….

Race……………………………Ethnicity…………………………...Main Language……………………………

Address……………………………………………………………………………..….ZIP…...………..

Phone(H)…………………….…… Phone(Cell)……………………….. Phone(W)……………………….Indicate Primary Ph……

E-mail address………………………………….confidential? Yes or No Driver's Lic #............……………

Preferred Pharmacy (address/ph)………………..…………………….…………

Occupation:……………………………… Employer Name/Address…………………………………………………ZIP………………

EMERGENCY CONTACT NAME……………………………………………………….Phone ..………………………………

Address:……………………………………………………………….ZIP…………………..Relation to patient………………………...…

HOW DID YOU HEAR OF US?..

IF PATIENT IS MINOR, GIVE RESPONSIBLE PARTY NAME………………………………………………………..…

Date of Birth………………………………Gender……….. Phone (H)……………………….Phone (W)………………………....

Marital Status ……………SSN…..Driver's Lic #........…………………………….……

Address…………………………………………………………………………………………………….ZIP…....………......

Employer Name and Address…………………………………………………………………………….Zip……………………

PRIMARY INSURANCE INFORMATION (Please give card to receptionist to copy)

INSURANCE NAME………………………………………………ID #.. GRP#..............................

Policy Holder Name…………………………………………………………………………..Date of Birth……..………………………

SSN……………………………………………………. Patient relation to policy holder: Child………Spouse…………Other..………

Address……………………………………………………………………………………………...ZIP……………………

Phone (H)………………………… Phone (W)……………………………………Phone (Cell)…………………..…………..…...

Employer Name/Address……………………………………………………………………………………..ZIP………………...

SECONDARY INSURANCE INFORMATION (Please give card to receptionist to copy)

INSURANCE NAME………………………………………………ID #.. GRP#..............................

Policy Holder Name…………………………………………………………………………..Date of Birth……..………………………

SSN……………………………………………………. Patient relation to policy holder: Child………Spouse…………Other..………..

Address……………………………………………………………………………………………...ZIP……………………

Phone (H)………………………… Phone (W)……………………………………Phone (Cell)…………………..…………..…...

Employer Name/Address……………………………………………………………………………………..ZIP………………...

AUTHORIZATION FOR TREATMENT/BENEFIT ASSIGNMENT AND ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I give my authorization for treatment and release of medical information to Dr. Dan Bautista and to my insurance companies to facilitate my claims. I authorize my insurance benefits to be paid directly to Dr. Bautista, realizing **I am ultimately responsible for any and all portions of the charges not paid by my insurance plan(s) as allowed per contract with Dr. Bautista**. I hereby authorize Dr. Bautista to release any medical or incidental information to other physicians or facilities that may be referred to by this office.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF FINANCIAL POLICIES I acknowledge that I have read, understood and received a copy of the practice's Financial Policy. This includes acknowledgment of collection agency fees that may be added to delinquent accounts.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I am aware of this Practice's Notice of Privacy Practices and understand that my protected health information may be used by this Practice as described in the notice.

By signing, I have read, understood and accept the above.

PATIENT/LEGAL GUARDIAN NAME…………………………………………………………………………………………..

PATIENT SIGNATURE……………………………………………………………………...….DATE………..………………………

HEALTH QUESTIONAIRE

(To be completed by patient)

TODAY'S DATE…….

NAME……..……..……
DATE OF BIRTH…… AGE……..…….…..
DRUG ALLERGIES……..……...

CHIEF COMPLAINTS (*Please list in order of importance, present health concerns, symptoms, or problems you are experiencing*)

……
……
……
……

HOSPITALIZATIONS (*If you have been in the hospital overnight, state year, illness/operation. Do not include pregnancies.*)

YEAR	ILLNESS/SURGERY	YEAR	ILLNESS/SURGERY

PAST MEDICAL HISTORY (*Have you ever had the following, circle YES or NO, leave blank, if uncertain*)

AIDS/HIV+	Y	N	Glaucoma	Y	N	Pneumonia	Y	N
Anemia	Y	N	Heart Disease	Y	N	Polio	Y	N
Arthritis	Y	N	Hemorrhoids	Y	N	Rheumatic	Y	N
Asthma	Y	N	Hepatitis	Y	N	Scarlet fever	Y	N
Back trouble	Y	N	Hernia	Y	N	Smallpox	Y	N
Bladder infections	Y	N	High or low B/P	Y	N	Stroke	Y	N
Bleeding tendency	Y	N	Hives or eczema	Y	N	Thyroid disease	Y	N
Bronchitis	Y	N	Infectious Mono	Y	N	Transfusions	Y	N
Cancer	Y	N	Kidney Disease	Y	N	Tuberculosis	Y	N
Chickenpox	Y	N	Measles	Y	N	Ulcer	Y	N
Diabetes	Y	N	Migraines	Y	N	Venereal disease	Y	N
Diphtheria	Y	N	Mitral valve	Y	N	Whooping cough	Y	N
Epilepsy	Y	N	Mumps	Y	N	Any other disease	Y	N
Depression	Y	N	Anxiety Disorder	Y	N	Any psychiatric illness	Y	N

COMMENTS……..……
……
……
……

FAMILY HISTORY *(Has any blood relative had any of the following: circle YES or NO, leave blank if uncertain)*

			RELATIONSHIP				RELATIONSHIP
Allergies	Y	N	……..	Epilepsy	Y	N	……
Anemia	Y	N	……..	Heart Disease	Y	N	……
Bleeding tendency	Y	N	……..	High blood Pressure	Y	N	……
Cancer	Y	N	……..	Stroke	Y	N	……
Diabetes	Y	N	……..				

PLEASE FILL UP BACK SIDE →

MEDICATIONS DOSAGE TIMES/DAY

…….…..........
……...……..
……………………………………………………………………………………………….……….……..……
……………………………………………………………………………………………….……….……..……
……………………………………………………………………………………………..………..………
…………………………………………………………………………………………….………….....……....

SOCIAL HISTORY

Tobacco	Y	N	Packs per day……………………..for ……………..years
Alcohol	Y	N	Drinks per day……………………………………………….
Caffeine	Y	N	Cup per day……………………………………………….
Illegal Drugs	Y	N	Type…………………………………………………….

Marital Status………………………………………………………………………………...……………..
Occupation…………………………………………………...……………………………………………..

The last time you had a (list year)

Flu vaccine……………………………………..	Tetanus shot…………………………………………….
Hepatitis vaccine……………………………….	TB test…………………………………………………..
Pneumonia shot……………………………...	Rubella vaccine…………………………………………
Stool blood test…………………………………	Rectal exam……………………………………………..
Sigmoid exam…………………………………..	Eye exam………………………………………………..
Cholesterol test…………………………………	PSA...………………………………………….……..

HEARING HEALTH

Do others complain that you watch television with the volume too high?	Yes	No
Do you frequently have to ask others to repeat themselves?	Yes	No
Do you have difficulty understanding when in groups or in noisy situations?	Yes	No
Do you have to sit up front in meetings or in church in order to understand?	Yes	No
Do you difficulty understanding women or young children?	Yes	No
Do you have trouble knowing where sounds are coming from?	Yes	No
Are you able to understand when someone talks to you from another room?	Yes	No
Have others told you that you don't seem to hear them?	Yes	No
Do you avoid meetings or social situations because you "can't understand"?	Yes	No
Do you have ringing or other noises (tinnitus) in you ears?	Yes	No

FOR WOMEN ONLY

Age at onset of menstrual period………………………………………………………………………...
Date of last menstrual period……………………………………………………………………………
Use birth control Y N Type………………………………………………………………...
Number of pregnancies…………………………… Number of live births……………………………….
Number of abortions……………………………… Number of miscarriages……………………………….

Year of last:

Breast exam……………………………………….. Results…………………………………………………
Mammogram……………………………………… Results…………………………………………………
Pap…………………………………………….... Results…………………………………………………