Dickson Street Clinic

www.dicksonstclinic.com

C.R Magness, M.D

Diana Holte, APRN

PATIENT INFORMATION – Please Print

Date:_____

Name _____
Last First MI

Gender: __ M __ F Date of Birth _____SSN _____-_____-_____

Address:_____Apt#_____

City:_____ State:_____ Zip_____

Home Phone:_____ Cell _____

Preferred Contact: *(circle one)* **Home Work Cell Email**

Employer: _____ Work Phone: _____

Martial Status: *(circle one)* **Single Married Widowed Divorced Partner**

Race: *(circle one)* **White African American Asian Native Hawaiian/Pacific Islander**
Native American Indian/Alaskan Other Race: _____

Preferred (Primary) Language: _____ Physician History: _____
_____

Preferred Pharmacy:_____

Appointment Reminder: Please select how you would like to be notified of your appointment. You may select more than one option. *(circle one)*: **Email Text Phone Call**
*Messages and data rates may apply for text messages. To change your preferences at anytime, you may fill out an Appointment Reminder form at the receptionist desk.

SPOUSE or PARENT (if minor) INFORMATION

Name: _____ Date of Birth_____Social Security _ _____

Employer _____Address_____Phone _____

EMERGENCY CONTACT INFORMATION

Relative or Friend not in the home

Emergency Contact _____Relationship _____

Phone_____Address_____City_____State____Zip _____

PATIENT NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received a copy of the Patient Notice of Privacy Practices from Dickson Street Clinic.

SIGNATURE _____DATE _____
In the event this Acknowledgment form is being executed by a personal representative, guardian or parent, please print your name, date of birth, social security number, and relationship to the patient here.

_____

PERSON RESPONSIBLE PARTY FOR PAYMENT

- My self/My Spouse (skip to the next section) OR:(list Father, Mother, Guardian or other)

Name:_____ DOB: _____

Address:_____Apt#_____Lot# _____

Street Name:_____City:_____State:_____ Zip:_____

HEALTH INSURANCE INFORMATION

Please provide a copy of your insurance card to the receptionist

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- ***Medicare*** ***Medicare No. _____-_____-_____-_____*** ***Effective Date _____***

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dickson Street Clinic for any services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid and its agents any information needed to determine these benefits payable for related services.

_____

PRIMARY INSURANCE_____

ID #_____ GP#_____Phone# _____

Address_____City_____State_____Zip_____

Policy Holder's Name_____ DOB_____ SS#_____

Relationship to Policy Holder: *(Circle one)* **Self Spouse Child Step-Child Other:_____**

SECONDARY INSURANCE_____

ID#_____GP#_____Phone# _____

Address_____City_____State_____Zip _____

Policy Holder's Name_____ DOB_____ SS#_____

Relationship to Policy Holder: *(Circle one)* **Self Spouse Child Step-Child Other:_____**

INSURANCE AUTHORIZATION & FINANCIAL AGREEMENT

I hereby authorize Dickson Street Clinic to give my insurance company or companies all information they may require concerning my case, and I hereby assign to the physician(s) all payments for medical services rendered. I understand that I am responsible for any amount not covered by my insurance. I agree to pay any co-pay and amount due at the time of service. Further, I agree to be responsible for any and all cost of collection to include court costs and a reasonable attorney fee.

Signed _____Date _____

HOW DID YOU HEAR ABOUT US?

- Recommended by a friend or family member
- Clinic web site, www.dicksonstclinic.com
- E-mail, Facebook or Twitter
- Signs or location
- My employer
- Other: *Please specify* _____

Thank you for choosing Dickson Street Clinic.

ADULT HEALTH HISTORY
www.dicksonstclinic.com

Please complete the information below to help your doctor evaluate your health.

Name _____ Date_____ Date of Birth_____

Why are you visiting the doctor? _____

Do you feel that you are basically healthy? *(cirlce one)* **Yes** **No** What is bothering you? _____

Mark any diseases known to have occurred in the family with the appropriate initial: **M** (Mother), **F** (Father), **GM** (grandmother), **GF** (grandfather), **A** (aunt), **U** (uncle), **C** (cousin), **B** (brother), **S** (sister).							
Alzheimer		Cancer		Hearing Prob.		Obesity	
Asthma		Stroke		Cholesterol		Blood Clots	
Alcoholism		Depression		High Blood Pressure		Kidney Prob	
Blood Disease		Developmental Problems		Mental Disease		Seizures	
Coronary Artery Dis		Diabetes		Migraines		Sickle Cell	

About You:
Education:*(circle one)* **Elementary** **High School** **GED** **College** **Graduate School** **Tech School**

Occupation_____*(circle one)* **Single** **Married** **Widowed** **Divorced**

Tobacco Use: Type: *(circle one)* **Cigarettes** **Smokeless Tobacco**

Current -Everyday, how much?_____ Current -occasional, how much?_____
Former, how much?_____ Never _____

Alcohol Use: *(circle one)* **Yes** **No** Formerly How much and often? _____

Illicit drug use:*(circle one)* **Yes** **No** Formerly Please list_____

Allergies: Medicines _____Other _____

Medications: *Please list medications you take regularly.*
Over the Counter (Include vitamins and supplements) :_____
_____

Prescription: _____
_____
_____
_____

Your Health History

Medical Conditions: _____
_____
_____

Operations *(Please include where and when)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please mark "yes" to anything you have experienced recently or frequently:

	Y	N	When		Y	N	When
General:				***Gastrointestinal:***			
Feel anxious, depressed, or irritable				Recent change in bowel habits			
Nervous breakdown				Diarrhea			
Fever, Chills, Night Sweats				Frequent indigestion or gas			
Skin:				***Genitourinary:***			
Skin Rashes				Blood in urine			
Eyes, Ears, Nose, Throat:				Burning when you pass urine			
Severe or frequent headaches				Sexually transmitted disease			
Hearing trouble				***Musculoskeletal:***			
Goiter or thyroid trouble				Arthritis			
Vision trouble				**Health Changes:**			
Respiratory:				Has your weight changed in the past year?			
Shortness of breath				Approximate weight 1 year ago_____			
Asthma				***Other:***			
Cough				Excessive thirst			
Cardiovascular:				Swollen glands			
Heart trouble Pain in chest				Hay fever or allergies			

For Women

Are you currently pregnant? *(circle one)* **Yes** **No** Pregnancies(#):_____ Miscarriages:_____

Living children:_____ Age when menstrual periods began _____

Patient Signature_____Date_____