



# Patient Demographic & Insurance Information

## PATIENT INFORMATION

Patient's Social Security Number: \_\_\_\_\_

Name of Patient \_\_\_\_\_  
First Middle Last

Birth Date \_\_\_\_\_ Gender  M  F Race \_\_\_\_\_

Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's Home Phone (\_\_\_\_) \_\_\_\_\_ Patient's Work Phone (\_\_\_\_) \_\_\_\_\_

Patient's Cell Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

### Patient's Relationship to Insured?

Self  Child  Spouse  Guardian  Other \_\_\_\_\_

## Parent/Billing Information/Responsible Party/Guarantor for Encounter

Name of Parent or Insured \_\_\_\_\_  
First Middle Last

Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Parent or Guarantor's Social Security Number: \_\_\_\_\_

Gender  F  M

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

## Household Assessment

Total Number of Individuals in household: \_\_\_\_\_

FULL NAME

AGE

PROOF OF INCOME


- Social Security
- SSI Disability
- Check Stub
- Food Stamp Award Letter
- Federal Income Tax Return
- Other: \_\_\_\_\_

### Insurance Coverage - Primary

Name of Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Name or Number \_\_\_\_\_

### Insurance Coverage - Secondary

Name of Insurance \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Name or Number \_\_\_\_\_

**Additional Patient Information**

**Marital Status**     Single     Married     Divorced     Separated  
**Patient's Employment Status**     Full-Time     Part-Time     None  
**Spouse's Employment Status**     Full-Time     Part-Time     None  
**Student Status (if Applicable)**     Full-Time     Part-Time     None    GRADE: \_\_\_\_\_  
**Military Status:**     Active Duty     Active Reserve     General Discharge     Honorable Discharge  
                                   National Guard     Other Discharge     Retired     Separated

Referred By: \_\_\_\_\_

**Financial Responsibility Agreement**

I/We hereby authorize Capitol City Family Health Center, Inc. to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We understand that fees for services are determined prior to service. Once seen by the provider, the provider may determine a need for additional services such as lab work or more x-rays. I/We also understand that a procedure may be determined to be more complicated than expected, resulting in additional charges. I/We understand that I am responsible for any additional charge(s) for services as indicated by my provider. I/We authorize payment of medical benefits to Capitol City Family Health Center, Inc. I/We hereby authorize Capitol City Family Health Center, Inc. to act on my behalf in accessing hospital medical records when and if needed. I/We do hereby give my consent for treatment by Capitol City Family Health Center, Inc.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guardian Signature

**Acknowledgement of Receipt of  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided Capitol City Family Health Center's Privacy Practices ("Notice"):

- \* It tells me how CCFHC will use my health information for the purposes of my treatment, payment for my treatment, and CCFHC's health care operations
- \* The Notice also explains in more detail how CCFHC may use and share my health information for other than treatment, payment and health care operations.
- \* CCFHC will also use and share my health information as required/permitted by law.

Patient's Name \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guardian Signature

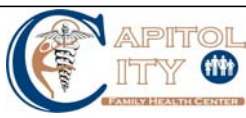
**Acknowledgement of Receipt of  
PATIENT RIGHTS AND RESPONSIBILITIES**

I acknowledge that I have been provided Capitol City Family Health Center's Patient Rights and Responsibilities.

Patient's Name \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Guardian Signature



# Patient Medical History

Patient Name: \_\_\_\_\_

Patient Age: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

BMI: \_\_\_\_\_

Frame: \_\_\_\_\_

## CONDITIONS: Check (√) conditions you have or had in the past:

<input type="checkbox"/> AIDS	<input type="checkbox"/> GLAUCOMA	<input type="checkbox"/> MULTIPLE SCLEROSIS	<b>FAMILY HISTORY</b> <input type="checkbox"/> HYPERTENSION <input type="checkbox"/> DIABETES <input type="checkbox"/> BLEEDING DISORDERS <input type="checkbox"/> HEART DISEASE <input type="checkbox"/> STROKE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> TB <input type="checkbox"/> CANCER (SITE) _____ <input type="checkbox"/> OTHER _____
<input type="checkbox"/> ALCOHOLISM	<input type="checkbox"/> GOITER	<input type="checkbox"/> MUMPS	
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> GONORRHEA	<input type="checkbox"/> PACEMAKER	
<input type="checkbox"/> ANOREXIA	<input type="checkbox"/> GOUT	<input type="checkbox"/> PNEUMONIA	
<input type="checkbox"/> APPENDICITIS	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> POLIO	
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> PROSTRATE PROBLEMS	
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> PSYCHIATRIC CARE	
<input type="checkbox"/> BLEEDING DISORDERS	<input type="checkbox"/> HERNIA	<input type="checkbox"/> RHEUMATIC FEVER	
<input type="checkbox"/> BREAST LUMP	<input type="checkbox"/> HERPES	<input type="checkbox"/> SCARLET FEVER	
<input type="checkbox"/> BRONCHITIS	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> STROKE	
<input type="checkbox"/> BULIMIA	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> SUICIDE ATTEMPT	
<input type="checkbox"/> CANCER	<input type="checkbox"/> HIV POSITIVE	<input type="checkbox"/> THYROID PROBLEM	
<input type="checkbox"/> CATARACTS	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> TONSILLITIS	
<input type="checkbox"/> CHEMICAL DEPENDENCY	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> TUBERCULOSIS	
<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> MEASLES	<input type="checkbox"/> TYPHOID FEVER	
<input type="checkbox"/> DIABETES	<input type="checkbox"/> MIGRAINE HEADACHES	<input type="checkbox"/> ULCERS	<b>WOMEN ONLY:</b> <input type="checkbox"/> Date of last menstrual period: _____ <input type="checkbox"/> Date of last pap smear: _____ <input type="checkbox"/> Are you pregnant? YES or NO <input type="checkbox"/> Number of children: _____ <input type="checkbox"/> Have you had a Mammogram? YES or NO <input type="checkbox"/> Are you taking any type of birth control? YES or NO What type? Pills Shots Other
<input type="checkbox"/> EMPHYSEMA	<input type="checkbox"/> MISCARRIAGES	<input type="checkbox"/> VAGINAL INFECTIONS	
<input type="checkbox"/> EPILEPSY	<input type="checkbox"/> MONONUCLEOSIS	<input type="checkbox"/> VENERAL DISEASE	

## PAST MEDICAL HISTORY

### Please list all previous operations

Surgery	Approximate Date of
_____	_____
_____	_____
_____	_____

### Have you ever had a blood transfusion?

YES or NO

If yes, please give approximate dates:

### Past Major Medical Problems:

\_\_\_\_\_

## MEDICATIONS & ALLERGIES

### Are you taking any prescriptions or over-the-counter medications?

YES  NO

If yes, please list medications below:

MEDICATIONS	DOSAGE	ALLERGIES
_____	_____	_____
_____	_____	_____
_____	_____	_____

## HEALTH HABITS - Please (√) and describe how much.

Caffeine \_\_\_\_\_

Tobacco \_\_\_\_\_

Drugs \_\_\_\_\_

Alcohol \_\_\_\_\_

### SEXUAL ACTIVITY

Male  Female  Both

Number of Lifetime Partners \_\_\_\_\_

History of STD's: \_\_\_\_\_