Beth Israel Deaconess Hospital
Plymouth

DATE: ____________________

NAME: ____
Prefix First Middle Last Previous Last Name

D.O.B.______/______/______ MARITAL STATUS: M S D W

ADDRESS: ____
(CITY) (STATE) (ZIP)
PRIMARY TELEPHONE#: ________________________SECONDARY#:_____________________________
Is it ok to leave a message at these numbers: YES NO

EMAIL ADDRESS: ____________________________May we communicate via E-Mail: YES NO

DO YOU HAVE A HEALTH CARE PROXY? YES NO HAS THIS BEEN PROVIDED TO US? YES NO

IS VISIT DUE TO A WORKMAN'S COMPENSATION, MOTOR VEHICLE ACCIDENT OR PERSONAL INJURY CLAIM? YES NO

PRIMARY
INSURANCE: _______________________________________POLICY#: ___________________________

SUBSCRIBER: ___________________________________RELATIONSHIP TO PATIENT: _______________

SECONDARY
INSURANCE: ______________________________________POLICY#: ____________________________

PHARMACY: ___________________________ADDRESS & PHONE _______________________________

PRIMARY CARE PHYSICIAN: ________________________TOWN & PHONE _______________________

EMERGENCY
CONTACT: ________________________PHONE# ________________ RELATIONSHIP:_______________

REFERRAL FROM PHYSICIAN? IF YES, WHO? ____

RACE (PLEASE CIRCLE)	ETHNICITY (PLEASE CIRCLE)	LANGUAGE
American Indian or Alaska Native	Central American	English
Asian	Cuban	Spanish
Native Hawaiian	Dominican	Portuguese
White	Hispanic or Latino	Other
Black	Latin American/Latin/Latino	
Hispanic	Mexican	_________________
Other Race	Not Hispanic or Latino	
Other Pacific Islander	Puerto Rican	
Unreported/Refused to Report	South American	

HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE)

Mail Internet TV/Radio Internet Billboard Insurance Company Word of Mouth (family/friend)

Beth Israel Deaconess Hospital
Plymouth

NAME: ____ DATE: ___________________________

TO ALL MY PATIENTS

WE ARE REQUSTING THAT YOU MAKE A LIST OF ALL YOUR MEDICATIONS AND THEIR DOSAGE. THIS LIST SHOULD INCLUDE ALL MEDICATIONS, EYE DROPS, PRESCRIBED PILLS AND OVER THE COUNTER MEDICATIONS. ***BE SURE TO NOTIFY THE OFFICE WHEN YOU HAVE A CHANGE.***

YOU ARE ALSO REQUESTED TO BRING ALL OF YOUR MEDICATIONS AND A LIST OF THEM WHEN YOU ARE ADMITTED.

THANK YOU!!

NAME OF MEDICATION	STRENGTH	HOW MUCH/HOW OFTEN

*****BE SURE TO LIST ALL ALLERGIES*****

____

____

____

____

____

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize and direct my payment of medical benefits to Jordan Physician Associates for any services furnished to me by the physicians. I authorize the release of any medical information, including diagnosis and records of any treatment and/or examination rendered to my child or me during the period of such medical services to process the insurance claim and medical benefits.

____ ________________

Signature of patient or responsible party Date

STATEMENT OF FINANCIAL RESPONSIBILITY

In the event that my health plan determines a service to be "not covered", I understand that I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including any fees for collection services needed.

____ ________________

Signature of patient or responsible party Date

ACKNOWLEDGEMENT RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have read the Notice of Privacy Practices and have been offered a copy.

____ ________________

Signature of patient or responsible party Date

PRESCRIPTION HISTORY CONSENT

____ ________________

Signature of patient or responsible party Date

I give permission to the following people to have access to my medical records:

____

____

Patient Name: **Age:** **Medical record numbers:**

MEDICAL HISTORY QUESTIONAIRE

1. **Who is (are) your regular Doctor(s)?** **2. Date ____________**
____

3. Your reason for visit today
____

4. When did this start? ____________________Ever had this before? _____________ When?
____

5. Are you having pain? ___________

If so, on a scale from 1 (mild) to 10 (severe) how bad is it?

(mild) 1 2 3 4 5 6 7 8 9 10 (severe)

Where is it located?
____

Does the pain go anywhere (or radiate)? ___________ If yes, where
____

How long have you had the pain
____

Is it constant or does it come and go? __________________how frequently?
____

Can you describe it? (circle) Dull Achy Crampy Sharp Stabbing Burning other
____

Does anything make it better?
________________________________**worse?**___________________________________

Are you having bleeding? ______________________How often? ____________________How much?____________

6. Past Medical Problems: (Asthma, diabetes, high blood pressure, heart problems, etc…)

7. Past Surgery: (Appendix, Gall bladder, Hysterectomy, Colon, Heart Bypass, Stents, etc…)

____
____
____

8. List all other hospitalizations, operations, and/or injuries: you have were done:

Year **Reason** **Hospital**

____ ____________________

____ __________________

____ ________________

____ _________________

____

____________________ ____

____ ________________

9. Check off any of the following tests had; give month and year they

Date **Test** **Reason**

☐ __________ **Chest x-ray**

☐ __________ **Colonoscopy**

☐ __________ **Upper GI series**

☐ __________ **Barium enema**

☐ __________ **Arteriogram**

☐ __________ **Ultrasound** ____________________

☐ __________ **Cat Scan or MRI**

10. Do you currently have any of the following?

Y N	Y N	Y N	Y N	Y N
☐☐ nausea	☐☐ black stools	☐☐headache	☐☐chest pain	☐☐ fever
☐☐vomiting	☐☐ vision trouble	☐☐ weight loss	☐☐ swollen feet or ankles	☐☐ fatigue
☐☐diarrhea	☐☐swollen glands	☐☐short of breath	☐☐painful urination	☐☐heartburn
☐☐hemorrhoids	☐☐ depression	☐☐ cough	☐☐ easy bruising/bleeding	☐☐ rashes
☐☐ rectal bleeding	☐☐ anxiety	☐☐ sweats	☐☐ muscle pains	☐☐ joint pain

☐ ___ all others negative

11. Specifically, are you taking Aspirin, Plavix, Pradaxa, Coumadin, Heparin or Lovenox? __________

12. Drugs or medicines to which you have a bad or **allergic reactions**:

Drug: _________________________________ Reaction: ___________________________

13. FAMILY HISTORY
Specifically, any Family History of Cancer, Heart disease, Inflammatory Bowel or Crohn's Disease?

Relative	Age if Living	Cause of Death if Deceased	Age at Death	Medical Problems
Father				
Mother				
Brother(s)				
Sister(s)				
Spouse				
Children				

14. Do you smoke? ☐ YES ☐NO

Have you ever? ☐ YES☐NO
Est amount:____packs/day
How many years? ______
When did you quit? _____

15. Do you use alcoholic beverages? ☐YES ☐NO

Estimate amount: _____drinks per night
_____ per week
_____ Per month

16. Occupation:
____

17. Are you aware of any unusual health hazards or exposures in your occupation?

☐YES ☐NO If so, specify:
____
____
____

18. Are you disabled from work: Yes NO If so, date last worked:
____

19. Do you follow a special diet? Yes NO Specify:
____

20. Specify foreign travel in past 10 years:
____

THANK YOU!