PATIENT INFORMATION AND INSURANCE

PATIENT'S NAME _____ SEX (M / F)
FIRST MI LAST Generation (Jr. Sr. 1st, 2nd)

MAILING ADDRESS: _____
STREET (PO BOX) CITY STATE ZIP

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY # _____ E-MAIL: _____

RACE: WHITE / INDIAN (NATIVE AMERICAN OR ALASKAN) / ASIAN / BLACK OR AFRICAN AMERICAN / ISLANDER / DECLINED

ETHNICITY: ARE YOU HISPANIC OR LATINO? YES / NO PRIMARY LANGUAGE: ENGLISH / SPANISH / OTHER _____

MARITAL STATUS: DIVORCED/MARRIED/PARTNER/SINGLE/WIDOWED

PRIMARY CARE PHYSICIAN:_____ DATE LAST SEEN: _____

EMERGENCY CONTACT AND RELATIONSHIP: _____ EMERGENCY PHONE: _____

EMPLOYMENT STATUS: FULL/PART/ NOT EMPLOYED/RETIRED/STUDENT(GRADE:__)

PLACE OF EMPLOYMENT: _____ WORK TITLE:_____

INSURANCE AND BILLING INFORMATION
PLEASE COMPLETE EVEN IF INSURANCE CARD WAS COPIED

Please note: If you do not provide the correct information at the time of your visit, we will be unable to bill your insurance company. You will then be responsible for payment in full at the time of the visit. Please provide a copy of your insurance card(s).

PRIMARY INSURANCE: _____ EFFECTIVE DATE: _____

GROUP NAME: _____ GROUP NUMBER: _____

INSURED ID NUMBER: _____ CO-PAY AMOUNT : _____

RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / STEPCHILD / LIFE PARTNER / OTHER

INSURED NAME:_____ INSURED DATE OF BIRTH: _____ SEX (M / F)

SECONDARY INSURANCE: _____ EFFECTIVE DATE: _____

GROUP NAME: _____ GROUP NUMBER: _____

INSURED ID NUMBER: _____ CO-PAY AMOUNT : _____

RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / STEPCHILD / LIFE PARTNER / OTHER

INSURED NAME:_____ INSURED DATE OF BIRTH: _____ SEX (M / F)

INSURANCE AUTHORIZAITON AND ASSIGNMENT

Co-payments are due at the time of service. We will bill all contracted insurance companies, however, you are ultimately responsible for all charges whether or not paid by your Insurance Company. To avoid late payment fees or finance charges, all unpaid balances must be paid within 30 days. For your convenience we do accept Checks, Cash, Visa and MasterCard. Note: If paying by credit card, you are authorizing BMFS to keep your signature on file and to charge the credit card you have selected for any co-payments that are due or towards any balances on your account.

I hereby authorize BMFS to disclose my individually identifiable health information to the insurance carrier(s). BMFS will use and disclose my health information in order to obtain payment to the doctor for services rendered and allow insurance companies to process the claims. I understand that this authorization is voluntary. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Patient, Guardian &/or Insured Signature _____ DATE: _____

ALLERGIES

Name: _____
FIRST MI LAST Generation (Jr. Sr. 1st, 2nd)

PLEASE WRITE IN ANY ALLERGIES IF THEY ARE NOT LISTED.

CHECK BOX FOR NO KNOWN ALLERGIES ☐	ALLERGY	REACTION	ALLERGY	REACTION	ALLERGY	REACTION
	ANTI-INFLAMATORIES		IODINE		SEAFOOD	
	ASPRIN		LATEX		SULFA	
	CODEINE		NOVOCAINE		TAPE	
	DEMEROL		PENICILLIN			

MEDICATIONS

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING, PRESCRIPTION OR OVER THE COUNTER. _____

_____

_____

PHARMACY (name and city): _____

PAST MEDICAL HISTORY

PLEASE CHECK IF YOU ARE CURRENTLY HAVE OR EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS

____ AIDS/HIV
____ ALCOHOLISM
____ ANEMIA
____ ANXIETY/NERVOUSNESS
____ ARTHRITIS
____ ASTHMA
____ BIPOLAR
____ BLEEDING TENDENCIES
____ BLOOD TRANSFUSION
____ CANCER
____ CIRCULATION PROBLEMS
____ DEPRESSION
____ DIABETES
____ FIBROMYALGIA
____ GOUT
____ GLAUCOMA
____ HEARING DEFIENCY
____ HEART TROUBLE
____ HEPATITIS
____ HIGH BLOOD PRESSURE
____ LEG CRAMPS
____ LUNG PROBLEMS
____ MRSA
____ MUSCLE DISORDERS
____ OBESITY
____ PNEUMONIA
____ POLIO
____ PSORIASIS
____ RESTLESS LEG SYNDROME
____ SEIZURES
____ SINUS ISSUES
____ STROKE
____ TUMOR
____ ULCERS (LOCATION): _____
____ VARICOSE VEINS
____ OTHER _____
____ OTHER _____
____ OTHER _____
____ OTHER _____

SURGERIES

PLEASE LIST PREVIOUS SURGERIES:

_____

_____

_____

SOCIAL HISTORY

TOBACCO: NON-SMOKER___ Never Smoked___ formerly smoked____ CURRENTLY SMOKE____ packs/day; Snuff _____ cans/week

ALCOHOL USE # PER: NONE_____ DAY _____ WEEK _____ MONTH _____ YEAR _____

WHAT NON-WORK RELATED ACTIVITES DO YOU DO THAT INVOLVE BEING ON YOUR FEET? _____

_____

FAMILY HISTORY: PLEASE SPECIFY IF ANY MEMBER OF YOUR FAMILY HAD THE FOLLOWING CONDITIONS

ADDICTIONS__ BLEEDING DISORDERS___ BLOOT CLOT__ CANCER__ DIABETES__ HEART DISEASE___ OTHER (SPECIFY) _____

HAVE YOU HAD YOUR FLU SHOT WITHIN A YEAR ? _____ YES _____ NO

HAVE YOU HAD A TETNUS SHOT IN THE LAST 10 YEARS? _____ YES _____ NO

SHOE SIZE: _____ WEIGHT: _____ HEIGHT: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE & NO SHOW / CANCELLATION POLICY

I acknowledge that I was provided a copy of the Notice of Privacy Practices and the No Show/Cancellation policy and that I have read (or had the opportunity to read if I so chose) and understand the posted notices.

_____ _____

Patient Name (Please Print) Parent or Authorized Representative (if applicable)

_____ _____

Signature Date

REVIEW OF SYSTEMS

PLEASE CHECK ALL SYMPTOMS THAT APPLY TODAY _____ NAME _____

Today's Date

PLEASE CHECK THIS BOX IF NOTHING APPLIES ☐

CONSTITUTIONAL	**0** Chills **0** Weight Gain	**0** Fatigue **0** Weight loss	**0** Fever	**0** Weakness
EAR, NOSE, MOUTH, THROAT	NOSE: **0** Breathing Difficulties **0** Sinus Issues	MOUTH: **0** Dental problems **0** Sore Gums **0** Speech Difficulty **0** Sore Mouth	EARS: **0** Ear hearing issues **0** Vertigo	THROAT NECK: **0** Hoarseness **0** Sore Throat
RESPIRATORY	**0** Asthma **0** COPD **0** Lung problems **0** Snoring	**0** Breathing difficulties **0** Coughing blood **0** Persistent cough **0** TB	**0** Bronchitis **0** Emphysema **0** Short of breath **0** Wheezing	**0** Chest tightness **0** Sleep apnea
CARDIOVASULAR	**0** Chest pain **0** Heart Problems **0** Pain in extremities **0** Weakness	**0** High blood pressure **0** Swelling **0** Varicose veins **0** Tightness in chest	**0** Extremity(s) Cool **0** Loss of sensation **0** Tiredness **0** Vascular grafts	**0** Heart murmur **0** Night sweats
GASTROINESTINAL	**0** Abdominal pain **0** Excessive hunger **0** Hernia **0** Poor appetite **0** Vomiting	**0** Bowel issues **0** Excessive thirst **0** Indigestion **0** Reflux **0** Weight loss	**0** Constipation **0** Hemorrhoids **0** Liver trouble **0** Stomach trouble	**0** Diarrhea **0** Hepatitis **0** Nausea **0** Ulcers
MUSCULOSKELETAL	**0** Arthritis **0** Fractures **0** Leg cramps **0** Scoliosis	**0** Bursitis **0** Heel pain **0** Muscle tenderness **0** Sprains	**0** Club foot **0** Hip pain **0** Neck pain **0** Stiffness	**0** Episodic weakness **0** Joint problems **0** Osteoporosis
PSYCHIATRIC	**0** Addictions **0** Constant overeating **0** Irritability **0** Panic attacks	**0** Anxiousness **0** Depression **0** Memory loss **0** Paranoia	**0** Attempted Suicide **0** Disorientation **0** Nightmares **0** Poor anger control	**0** Claustrophobia **0** Induced vomiting **0** Overreaction **0** Poor sleep pattern
SKIN	**0** Athlete's foot **0** Discolorations **0** Hair loss **0** Moles **0** Recent chicken pox	**0** Birthmarks **0** Dry scaly skin **0** Ingrown nails **0** Non healing wounds **0** Skin cancer	**0** Blisters **0** Excessive scar tissue **0** Itching **0** Psoriasis **0** Warts	**0** Deformed nails **0** Fungal nails **0** Lower leg ulcers **0** Rash
NEUROLOGICAL	**0** Brain disease **0** Dizziness **0** Muscle jerking **0** Paralysis **0** Spine disease	**0** Burning **0** Fainting **0** Nerve damage **0** Parkinson's disease **0** Tingling	**0** Confusion **0** Headaches **0** Neuroma **0** Strokes **0** Tremors	**0** Convulsions **0** MS **0** Numbness **0** Seizure **0** Weakness
ENDOCRINE	**0** Cold intolerance **0** Dry skin	**0** Endocrine related symptoms **0** Healing difficulty	**0** Diabetes **0** Heat intolerance	**0** Dry hair **0** Unusual fatigue
HEMATOLOGIC / LYMPH	**0** Anemia **0** Bruises easily **0** Lymphoma	**0** Bleeding easily **0** Edema **0** Recent transfusion	**0** Bloating **0** Fatigue **0** Swollen Glands	**0** Calf pain **0** Frequent nose bleeds **0** Water retention
ALLERGIC / IMMUNOLOGIC	**0** Arthritic flare up **0** Hepatitis Carrier **0** Sensitivity to dust	**0** Coughing **0** Hay fever symptoms **0** Sneezing	**0** Environmental allergies **0** HIV **0** Watery eyes	**0** Gouty attack **0** Seasonal Allergies
GENITOURINARY	**0** Bladder spasm	**0** Blood in urine	**0** Currently on Dialysis	**0** Currently Pregnant