Trinity Health

PATIENT INFORMATION SHEET

NAME: ____________________ **GENDER:** ________ **DOB:** ____________ **DATE:** ____________

ADDRESS: ____________________ **EMAIL:** ____________________ **PHONE:** ____________

____________________ **EMERGENCY CONTACT:** ____________ **PHONE:** ____________

INSURANCE INFORMATION

INS. CO. NAME ____________________ **POLICY HOLDER NAME:** ____________________

POLICY HOLDER'S DOB ____________________ **POLICY HOLDER'S SSN:** ____________________

PATIENT RELATIONSHIP TO POLICY HOLDER: ____________________

ALLERGIES: ____________________

List ALL MEDICATIONS you take, including over-the-counter (OTC) medications and vitamins. Include specific doses and when taken. If you don't know, please call your pharmacist to confirm.

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

PERSONAL MEDICAL HISTORY: (please circle all that apply)

ADHD	COPD / Emphysema	High Cholesterol	Rheumatoid Arthritis
Alcoholism	Dementia	HIV	Seizure Disorder
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Stroke
Anxiety	Diverticulitis	Lupus	Thyroid Disorder
Arythmia (irregular heart beat)	DVT (Blood Clot)	Liver Disease	Ulcerative Colitis
Arthritis	GERD (Acid Reflux)	Macular Degeneration	
Asthma	Glaucoma	Neuropathy	
Bipolar	Heart Disease	Osteopenia/Osteoporosis	
Bladder Problems / Incontinence	Heart Attack (MI)	Parkinson's Disease	
Bleeding Problems	Hiatal Hernia	Peripheral Vascular Disease	
Cancer: ____________	High Blood Pressure	Peptic Ulcer	
Headaches	Kidney Stones	Psoriasis	
Crohn's Disease	Kidney Disease	Pulmonary Embolism (PE)	

Menstrual Period	Date:______	Normal Abnormal
Colonoscopy	Yes / No	Normal Abnormal
Mammogram	Yes / No	Normal Abnormal
Dexa (Bone Density)	Yes / No	Normal Abnormal
Pap	Yes / No Date: ______	Normal Abnormal

Other medical problems not listed above:

____

Surgical History: **Please list all prior surgeries and approximate dates performed.**

____________________ ____________________

____________________ ____________________

Comments: (please feel free to comment on any other concerns you have)

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FAMILY HISTORY:

FATHER: Living: Age ______________ Deceased: Age ______________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: __________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

MOTHER: Living: Age ______________ Deceased: Age ______________

Alcoholism	Bipolar Disorder	Depression	High Cholesterol	Osteoporosis
Anemia	Cancer: __________	Diabetes 1 or 2	High Blood Pressure	Stroke
Asthma	COPD/Emphysema	DVT (Blood Clot)	Kidney Disease	Thyroid Disorder
Arthritis	Dementia	Heart Disease	Migraines	

Other: ____

SIBLINGS:

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List other medical providers you see on a regular basis

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I certify that I have read and agree to Trinity Health's (TH) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to TH all money to which I am entitled for medical expenses related to the services performed from time to time by TH, but not to exceed my indebtedness to TH. I authroize TH to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 60 days of notificaiton of the amount due will result in submission to an outside collection agency. A $15.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from TH by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

I consent to treatment by Trinity Health, under the advice from my provider (initials) ☐

Patient Signature ______________________________ Date: ____________________