



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)

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:

List other medical providers you see on a regular basis

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 authorize 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 notification 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: _____