PATIENT AUTHORIZATION FORM

PENTAHEALTH AT MT. AIRY FAMILY PRACTICE

I authorize release of any medical information necessary to process insurance claims for balance due PentaHealth at Mt. Airy Family Practice and or it's providers. I also authorize payment of medical benefits to PentaHealth at Mt. Airy Family Practice and/or it's providers for services rendered. I agree to accept responsibility for any deductibles or co-payments and for any balance due not covered by my insurance carrier.

Signature:____Date:__________________________

Patient Name (printed): ____

Name:______________________ Date of Birth:____________ Today's Date: ________

MEDICAL HISTORY

Please circle If you have any problems with or are presently concerned with any of these:

High blood pressure
Diabetes
Cancer
Heart Disease
Chest Pain or tightness
Shortness *of* Breath
Swollen Ankles
Palpitations
Lightheadedness
Rheumatic Fever
Frequent Urination
Headaches

Asthma
Bronchitis
Pneumonia
Persistent Cough
TB (tuberculosis)
Abdominal discomfort
Indigestion
Nausea
Vomiting
Diarrhea
Constipation
Hay fever

Blood In stool
Ulcers/gastritis
Change in bowel habits
Weight gaini1oss
Hemorrhoids
Gall bladder disease
Hepatitis or jaundice
Thyroid disease
Head or Neck radiation treatment
Colitis
Anxiety

Kidney disease/stones
Difficulty urination
Arthritis
Low Back problems
Skin diseases
Blood disorders
Sexually transmitted diseases
Anemia
Gout
Depression
Other.____________

PLEASE LIST AND SUPPLY THE DATES OF:

Operations:____

Hospitalizations: *(Other than surgery)* _________________________________

Do you take any medications (prescription or over the counter)? No __ Yes __

Name of medicine	Dose	How long have you taken this medicine?	Reason for taking

Latex Allergy ( ) No ( ) Yes If yes, how do you react? ________________________________

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES () No () Yes

If yes please list what you are allergic to and how you react.____

HABITS

Do you wear seatbelts? ( ) No ( ) Yes If no, why not?_______________________
Do you exercise? ( ) No ( ) Yes
Do you have smoke detectors? ( ) No ( ) Yes If no, why not?_______________________
Do/Did you smoke? ( ) No ( ) Yes If yes, how many packs per day?_________
Do you use Illicit drugs? ( ) No ( ) Yes If yes, what kind and how long?__________
Do you drink: Alcoholic beverages? ( ) No ( ) Yes If yes, how may per week?______________
Coffee or tea? ( ) No ( ) Yes If yes, how may per week?______________
Caffeinated soda? ( ) No ( ) Yes If yes, how much per day? ______________

Have you ever engaged in any activity which has put you at risk of contracting an STI? ( ) No ( ) Yes

Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? ( ) No ( ) Yes
If yes, explain:____

Do you have a Living Will or Advance Directive? ( ) No ( ) Yes

FAMILY MEDICAL HISTORY

Has any family member (including parents, grandparents, and siblings) had the following?

Illness	**Which family member(s)?**	**Approx. Age When Diagnosed**
Breast Cancer	____________________	____________________
Colon/Rectal Cancer	____________________	____________________
Other Cancer	____________________	____________________
High Blood Pressure	____________________	____________________
Heart Attack/Heart Disease	____________________	____________________
Stroke	____________________	____________________
Diabetes	____________________	____________________
Emotional/Mental Illness	____________________	____________________
Sickle Cell Disease or Trait	____________________	__________
Bleeding Clotting Disorder	____________________	__________
Asthma/Allergy/Hay	____________________	__________

Does anyone in your family have any other major medical problems not mentioned above? If yes, please describe:

____
____
____

Please list any other household or family members IMng with you (include relationship and date of birth):

____
____
____

PREVENTATIVE HEALTH PRACTICES

Have you had:

a Pneumonia shot?	No_ Yes_	If yes, when:________________
a Flu shot?	No_ Yes_	If yes, when:________________
a Tetanus shot?	No_ Yes_	If yes, when:________________
Hepatitis A or B shot?	No_ Yes_	If yes, when:________________

(If female)

Do you do monthly breast self-exam? ____________ When was your last breast exam?___________

When was your last pap smear? Any abnormal pap smears?______________

When was your last menstrual period? When was your last mammogram?______

(If Male)

Do you do monthly testicular self-exam?____

PATIENT REGISTRATION FORM

Please Complete Form Leaving No Blank Spaces

Rev 11/22/24

PATIENT INFORMATION *How did you hear about our office?*________________

Name *(Legal Name)*____

Home Address____

City________________ State_____________Zip____________

Home #: __________________________ Work #: _______________________________

E-Mail Address _________________________Cell #: ________________________________

Sex: M ( ) F ( ) Birthdate:____________

Employer:__________________ Occupation:_____________ Education Level: _________

Work Address____

City____________ State_____________Zip______________

PERSON TO CONTACT IN AN EMERGENCY

Name: ____

Address: ___________________________ City: __________State: ________ Zip: _______

Phone #: _________________________ Relationship: ____________________________

PERSON RESPONSIBLE FOR BILL

Name: ____________________________ Relationship:_____________Date of Birth: _____

Address: ___________________________ City: __________State: ________ Zip: _______

Home #: ___________________________ Work #: ________________________________