Coleman Medical Associates
310 S Pecos St, 2nd Floor
Coleman, TX 76834

Patient Information

Name:_____ DOB:_____

Address:_____City:_____State:____ Zip Code: _____

Social Security Number: _____ Gender: M F Marital Status: Married Single Divorced Widowed

Home Phone: _____ Cell Phone:_____ Work Phone: _____

May we leave a message on your machine? ___Yes ___No

Race: _____ Ethnicity:_____ Language _____

Email Address For Patient Portal:_____ Do you have an Advanced Directive on File? YES NO

Spouse Name: _____ (If marked yes, please provide office with copy)

Emergency Contact Person:_____ Phone: _____Relationship_____

Employment Information

Employer: _____ Occupation: _____

Employer Address: _____Employer Phone:_____

Responsible Party

Name of Person Responsible for this Account: _____Relationship to Patient: _____

Address: _____ Home Phone: _____

DOB: _____ Social Security #:_____

Employer: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

DOB: _____ SS#: _____

Insurance Company: _____ Policy/ID#: _____ Group#: _____

Ins Co. Address: _____ City: _____ State: _____ Zip: _____

I will be paying today by Cash_____ Check _____ Credit Card_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? _____YES _____NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured: _____ Relationship to Patient: _____

DOB: _____ SS#: _____

Insurance Company: _____ Policy/ID#: _____ Group#: _____

Secondary Insurance Company:_____

AUTHORIZATION TO RELEASE INFORMATION:

The clinic may disclose all or part of this patient's record to any insurance company, association or the Federal or State Government as may be necessary for the completion of all clinic claims. I understand that the information to be released may include information pertaining to mental or psychiatric related conditions and/or drug or alcohol abuse. A copy shall be as valid as the original.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____
Signature of Patient/Responsibility Party

Coleman Medical Associates
310 S Pecos St, 2nd Floor
Coleman, TX 76834

ALL AUTHORIZATIONS MUST BE SIGNED BY THE PATIENT OR BY THE NEAREST RELATIVE IN CASE OF A MINOR, OR WHEN PATIENT IS PHYSICALLY OR MENTALLY INCOMPETENT.

1. **Medical or Surgical Permit**:
   I, the undersigned or authorized party, hereby consent to medical or surgical procedures, x-ray exam or treatment, drugs (oral and/or injectable), and supplies which treating physicians or physician assistants deem necessary. I understand that there are inherent risks with any of these procedures.

2. **Authorization for Release of Physician Responsibility**:
   If I should leave before completing my medical or surgical procedures, examinations or treatment, I hereby release said physician or physician assistant and the clinic of any responsibility for medical condition.

3. **Consent for Release of Medical Information**:
   I hereby authorize Coleman Medical Associates to furnish any representative of the insurance company(s) under whose policy of insurance I am entitled to benefits for the payment of expenses of my medical treatment by the clinic with any information desired by said company(s) for the completion of any claims resulting from medical treatment.

4. I hereby authorize Coleman Medical Associates to furnish to any facility to which I am transferred any information as may be deemed necessary by the clinic. I hereby release the clinic from all legal liability of responsibility that may arise from the release of such records.

5. I hereby authorize payment directly to the physician of any insurance benefits otherwise payable to me for this period of treatment. I understand that I am financially responsible to the clinic for charges not covered by this authorization.

6. I have been informed that the clinic routinely provides medical care through mid-level practitioners. Physician Assistants or Advanced Certified Nurse Practitioners are supervised by the clinic's physicians and at all times can communicate with a physician when necessary.

7. I have been advised of the required privacy regarding my medical records as mandated by the HIPAA regulations. A complete copy of the policy has been made available to me. Because of the privacy regulations we must have your approval to discuss your medical condition with members of your family. Please indicate two family members with whom we may discuss your medical information.

Emergency Contact Information:

Name	Phone Number	Address	Relationship
Name	Phone Number	Address	Relationship

SIGNATURE INDICATES APPROVAL OF ALL THE ABOVE UNLESS OTHERWISE MARKED AND INITALED

Patient Name (Please Print): _____ Date: _____

Signature: X_____ Patient DOB: _____
(Must have guardian's signature if under 18)

Relationship to Patient: _____

Witness: _____

This authorization remains in effect unless revoked in writing

(Confidential)

Patient Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

Symptoms

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

Conditions

Check (✓) conditions you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

Medications

List medications you are currently taking.

_____

_____

_____

_____

Pharmacy Name_____ Phone_____

Allergies

_____

_____

_____

_____

_____

Health History

DC 2020

Family History

Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease		Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates _____

Serious Illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to the following:

	Stress		Hazardous Substances
	Heavy Lifting		Other

Occupation

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Revi By _____ Date _____

Coleman Medical Associates
310 S Pecos St, 2nd Floor
Coleman, TX 76834

Patient Name: _____

Please list any other providers you currently see

NAME OF PROVIDER	SPECIALTY	PHONE #	ADDRESS