



Telehealthdocs

WELCOME: PLEASE PROVIDE THE FOLLOWING INFORMATION

Patient Information

Date _____

Name _____

Preferred Name _____

Address _____

Apt. # _____ City _____

State _____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Birth Date _____ Age _____

Soc. Sec.# _____ Gender M F

Emergency Contact _____

Relationship _____

Emergency Contact Phone _____

Physician's Name _____

Phone _____

Date of last visit _____

Referred to Clinic by _____

Primary Insurance _____

Tel # _____

Policy Holder's Name: _____

Relationship _____

Policy#/ID _____

Group # _____

★ Preferred Pharmacy _____

Street _____

Telehealthdocs can provide our patients with appointment reminders and directions via e-mail and/or text messaging (*please enter information). **If you wish to receive information of this type, please sign below.**

SIGNED _____

*EMAIL _____

*TEXT PHONE # _____

Marital Information:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Domestic Partnership ☐ Other

Race:

☐ American Indian or Alaska Native ☐ Asian

☐ Caucasian ☐ White ☐ African American

☐ Native Hawaiian or Pacific Islander

☐ Unknown/Declined Other _____

Ethnicity (Please Check One)

☐ NOT Hispanic or Latino ☐ Hispanic or Latino

Primary Language Spoken _____

I have read or received a copy of Telehealthdocs Medical Group HIPPA Privacy Policy. (sign below)

SIGNED _____

As a patient or as a legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to TELEHEALTHDOCS. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request. **(sign below)**

SIGNED _____



WELCOME: PLEASE PROVIDE THE FOLLOWING INFORMATION

I. Have you experienced any of the following? (Please circle Positive answers only)

Chest pain (angina)	Coughing up blood	Headaches	Difficulty swallowing
Fainting spells/Dizziness	Bleeding problems	Blurred vision	Swollen ankles
Unexplained weight: loss/gain Lbs? _____	Blood in urine/stools	Bruising easily	Joint pain or stiffness
Fever	Diarrhea or constipation	Frequent vomiting	Shortness of breath
Night sweats	Frequent urination	Jaundice	Sinus problems
Persistent cough	Difficulty urinating	Dry mouth	Heart Palpitations
	ringing in ears	Excessive thirst	Shaky hands/Tremors

Other _____

II. Have you had or do you have any of the following? (Please circle Positive answers only)

Heart disease	Seizures	Kidney or bladder disease	Herpes
Family - heart disease	Surgeries Hospitalization	Stroke	Canker or cold sores
Heart attack	Diabetes	Eating disorders	Anemia
Stomach problems/ulcers	Family history of diabetes	Osteoporosis	Liver disease
Heart defects/murmurs	Tumors or cancer	Thyroid disease	Eye disease
Skin disease	Anxiety/Stress/Irritability	Asthma	Tuberculosis
Hardening of arteries	Arthritis, rheumatism	Hepatitis _____	
High/Low blood pressure	Emphysema/Lung disease	STD _____	

Other _____

III. Are you allergic to or have you had a reaction to any of the following? (Please circle Positive answers only)

Aspirin	Valium	Penicillin (*also circle below)	Tetracycline
Codeine	Demerol	*Severe/Moderate/Mild	Vicodin
Latex	Food	Erythromycin	Percodan

What type of reaction? _____

IV. Are you taking or have you taken any of the following in the last three months? (Please circle Positive)

Recreational drugs _____	Cortico - Steroids	Bisphosphonate (Fosamax)
Over-the-counter medicines	Tobacco in any form- Daily/Occasional	Antibiotics _____
Weight loss medications _____	Alcohol- Daily/Occasional	Aspirin

V. Women only (Please circle Yes or No)

Yes / No Are you/could you be pregnant? Yes / No Are you nursing? Yes / No Taking birth control pills?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my doctor of any change in my health and/or medication. Further, I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. **(sign below)**

Signature of Patient (Parent or Guardian) _____

Date _____

Relationship to Patient _____