Village At Newtown Medical Center, P.C.

11 Friends Lane, Suite 101 • Newtown, PA 18940-1803
(215) 579-1300 • Fax (215) 579-2816

PATIENT INFORMATION SHEET

LAST NAME: FIRST NAME: MI: AGE:

ADDRESS: CITY: STATE: ZIP:

SOCIAL SECURITY #: HOME PHONE: WORK PHONE:

BIRTH DATE: SEX: ❑ M ❑ F MARTIAL STATUS: ❑ S ❑ M ❑ W ❑ D OCCUPATION:

WHO REFERRED YOU TO THIS OFFICE?

FULL NAME AND ADDRESS OF RESPONSIBLE PARTY, IF DIFFERENT FROM ABOVE:

EMPLOYER'S NAME AND ADDRESS:

Insurance Information

INSURANCE NAME:

ADDRESS:

TELEPHONE: INSURED S.S.#:

GROUP#: IDENTIFICATION (POLICY):

C. INS: ID#:

Accident Information

ACCIDENT TYPE: W/C PERS. INJURY AUTO

DATE OF ACCIDENT:

INSURANCE NAME: ATTNY. NAME:

ADDRESS: ADDRESS:

CLAIM #:

Allergies

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES: ❑ NO ❑ YES

IF **YES,** PLEASE LIST NAME OF MEDICINE AND TYPE OF REACTION:

Gynecologic & Obstetric History

AGE AT ONSET OF PERIODS: FREQUENCY: LENGTH OF PERIOD:

PREGNANCIES: BIRTHS: MISCARRIAGES:

- PROLONGED OR ABNORMAL BLEEDING: ❑ NO ❑ YES
  PLEASE DESCRIBE:
- LEAKAGE OF URINE: ❑ NO ❑ YES
  PLEASE DESCRIBE:
- PELVIC PAIN: ❑ NO ❑ YES
  PLEASE DESCRIBE:
- ABNORMAL DISCHARGE: ❑ NO ❑ YES
  PLEASE DESCRIBE:
- HISTORY OF ABNORMAL PAP SMEAR: ❑ NO ❑ YES
  PLEASE DESCRIBE:

Past Medical History & Review of Systems

Please circle if you have had problems with, or are presently complaining of any of the following:

1. HIGH BLOOD PRESSURE
2. DIABETES
3. CANCER
4. HEART DISEASE
5. CHEST PAIN / CHEST TIGHTNESS
6. SHORTNESS OF BREATH
7. SWOLLEN ANKLES
8. PALPITATIONS
9. LIGHTHEADEDNESS
10. FREQUENT URINATION
11. ASTHMA
12. BRONCHITIS
13. PNEUMONIA
14. PERSISTENT COUGH
15. T.B.
16. HAY FEVER
17. ABDOMINAL DISCOMFORT
18. INDIGESTION
19. NAUSEA
20. VOMITING
21. CONSTIPATION
22. DIARRHEA
23. BLOOD IN STOOL
24. ULCERS
25. CHANGE IN BOWEL HABITS
26. UNEXPLAINED WEIGHT GAIN/LOSS
27. HEMORRHOIDS
28. GALL BLADDER DISEASE
29. COLITIS
30. HEPATITIS OR JAUNDICE
31. THYROID DISEASE
32. HEAD OR NECK RADIATION
33. HEADACHE
34. KIDNEY DISEASE
35. KIDNEY STONES
36. DIFFICULTY URINATING
37. ARTHRITIS
38. LOW BACK PROBLEMS
39. SKIN DISEASES
40. BLOOD DISORDERS
41. VENEREAL DISEASE
42. ANXIETY
43. DEPRESSION
44. ANEMIA
45. ALCOHOL ABUSE
46. DRUG ABUSE
47. GOUT
48.
49.
50.

Please List & Supply the Dates of:

OPERATIONS: HOSPITALIZATIONS OTHER THAN FOR SURGERY:

IMMUNIZATION HISTORY – HAVE YOU HAD: PNEUMOVAX IMMUNIZATION? ❑ NO ❑ YES WHEN?

HEPATITIS B? ❑ NO ❑ YES WHEN? FLU IMMUNIZATION? ❑ NO ❑ YES WHEN?

TETANUS IMMUNIZATION? ❑ NO ❑ YES WHEN? OTHER: ❑ NO ❑ YES WHEN?

WHEN WAS YOUR LAST: PAP SMEAR? BREAST EXAM? STOOL CHECK FOR BLOOD?

MAMMOGRAM? CHOLESTEROL CHECK? PROSTATE EXAM?

I, the undersigned (patient or legal guardian), authorize medical and/or surgical treatment, to be rendered by Village at Newtown Medical Center, P.C. and the staff, and assume financial responsibility.

Patient/Legal Guardian Signature

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PATIENT NAME: DATE:

Family History

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

ILLNESS	WHICH FAMILY MEMBERS?	APPROX. AGE WHEN DIAGNOSED
❑ CANCER (DESCRIBE TYPE)		
❑ HYPERTENSION (HIGH BLOOD PRESSURE)		
❑ HEART DISEASE		
❑ DIABETES		
❑ STROKES		
❑ MENTAL DISEASE (ANXIETY, DEPRESSION, ETC.)		
❑ DRUG OR ALCOHOL ADDICTION		
❑ GLAUCOMA		
❑ BLEEDING DISEASES		
❑ OTHER		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

DRUG NAME	DOSE	DRUG NAME	DOSE

Prevention

- DO YOU WEAR SEATBELTS? ❑ NO ❑ YES IF NO, WHY NOT?
- DO YOU WEAR A BIKE HELMET? ❑ NO ❑ YES
- DO YOU SMOKE? ❑ NO ❑ YES IF YES, HOW MANY PACKS PER DAY?
- DO YOU DRINK ALCOHOLIC BEVERAGES? ❑ NO ❑ YES IF YES, HOW MUCH PER WEEK?
- DO YOU DRINK COFFEE? ❑ NO ❑ YES IF YES, HOW MANY CUPS PER DAY?
- DO YOU DRINK TEA? ❑ NO ❑ YES IF YES, HOW MANY CUPS PER DAY?
- IS THERE A GUN IN YOUR HOME, IS IT OUT OF CHILDREN'S REACH AND UNLOADED? ❑ NO ❑ YES N/A
- DO YOU USE DRUGS? (MARIJUANA, COCAINE, CRACK, ETC.) ❑ NO ❑ YES IF YES, EXPLAIN:
- DO YOU HAVE A "LIVING WILL"? ❑ NO ❑ YES
- DO YOU HAVE A DONOR CARD? ❑ NO ❑ YES
- METHOD OF BIRTH CONTROL?
- HAVE YOU EVER ENGAGED IN ANY ACTIVITY WHICH HAS PUT YOU AT RISK OF AIDS? ❑ NO ❑ YES IF YES, EXPLAIN:
- DO YOU WISH TO BE TESTED FOR AIDS? ❑ NO ❑ YES
- HAVE YOU EVER WORKED WITH CHEMICALS, PAINTS, ASBESTOS, OR OTHER HAZARDOUS MATERIAL? ❑ NO ❑ YES IF YES, EXPLAIN:
- ARE YOU IN A RELATIONSHIP IN WHICH YOU HAVE BEEN PHYSICALLY HURT (E.G., SLAPPED, KICKED, PUNCHED, BRUISED BY YOUR PARTNER? ❑ NO ❑ YES
- DO YOU EVER FEEL AFRAID OF YOUR PARTNER? ❑ NO ❑ YES

ASSIGNMENT OF BENEFITS

I hereby authorize and direct that the payment for all professional services rendered to me at the Village at Newtown Medical Center, P.C. be paid directly to the Village at Newtown Medical Center, P.C. I hereby assign my rights to receive said proceeds for medical expenses directly to the Village at Newtown Medical Center, P.C., 11 Friends Lane, Suite 101, Newtown, Pennsylvania, 18940.

It is also understood and agreed that I am responsible for the full cost of all treatment rendered to me by the Village at Newtown Medical Center, P.C. I understand that the Assignment of benefits is accepted by the Village at Newtown Medical Center, P.C. as an accommodation to me and that I remain responsible for all bills that are not fully or promptly paid by my insurance carrier. I understand that any checks made payable to me on account for medical services rendered by the Village at Newtown Medical Center, P.C. shall be promptly endorsed over to the Village at Newtown Medical Center, P.C. in payment for the professional services rendered and invoiced.

I agree that I shall be responsible for any unpaid bills for professional services rendered.

PATIENT'S NAME DATE

WITNESS

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE FOR RELEASE OF MEDICAL INFORMATION AND PAYMENT

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or the Village at Newtown Medical Center, P.C. (the party who accepts assignment).

SIGNED DATE

I authorize payment of medical benefits to the Village at Newtown Medical Center, P.C. for services rendered.

SIGNED DATE

— MEDICARE PATIENTS RELEASE ONLY —

NAME OF BENEFICIARY HEALTH INS. CLAIM #

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to the Village at Newtown Medical Center, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related service."

BENEFICIARY SIGNATURE DATE