TRIPP FAMILY MEDICINE

Today's Date: _____

NEW PATIENT DEMOGRAPHIC INFORMATION

Last Name_____ First Name: _____ MI: _____

Preferred Name: _____ SS#_____-_____-_____ DOB:_____/_____/_____

Sex: Male Female Race *(circle one)*: Caucasian Hispanic Other _____

Mailing Address: _____ City/State: _____ Zip: _____

Preferred Phone: ( ) _____ Texting? Yes No

Secondary Phone: ( ) _____ Work Phone: ( ) _____

Email: _____ OK to email? Yes No

Employer & Address: _____

Parent/Spouse/Guardian Name: _____ Marital Status: Married Single Divorced Widowed

EMERGENCY CONTACT INFORMATION

Contact: _____ Relation: _____

Phone (1): _____ Phone (2): _____ Email: _____

Primary Insurance Policy Holder Information / Guarantor

Policy Holder name: _____ Phone: _____ SSN:____-____-_____

Address: _____ DOB: ____/____/_____ Relation to Patient: _____

Employer & Address: _____ Phone:_____

Is this person the GUARANTOR on the account? ___ Yes ___No

Secondary Insurance

Policy Holder name: _____ Phone:_____ SSN:____-____-_____

Address:_____ DOB: ____/____/_____ Relation to Patient:_____

Employer & Address: _____ Phone:_____

Pharmacy you use: _____ City: _____

Who (or what) influenced you to come see us? Doctor Family Friend Other Event

Billboard Banner Newspaper Mailer Phone Book TV Radio Internet Name: _____

TRIPP FAMILY MEDICINE

PATIENT MEDICAL HISTORY

CURRENT MEDICATIONS & DOSAGE (Please list type & dosage)

1. Medication _____ Dosage/how often _____
2. Medication _____ Dosage/how often _____
3. Medication _____ Dosage/how often _____
4. Medication _____ Dosage/how often _____

ALLERGIES WITH REACTIONS

1. Allergy _____ Reaction _____ Severity _____
2. Allergy _____ Reaction _____ Severity _____
3. Allergy _____ Reaction _____ Severity _____

PROCEDURES? Please list the date of your most recent:

1. PAP: date _____
2. Mammogram : date _____
3. Colonoscopy : date _____
4. Hospitalization : date _____ reason _____

SURGERIES? ___ Yes ___ No If yes, please list the year(s) and type(s) of surgery:

1. year _____ type _____
2. year _____ type _____
3. year _____ type _____

Former smoker? ___ Yes ___ No How long? _____
Do you use chewing tobacco or snuff? ___ Yes ___ No How much per day? _____
Do you smoke cigars or cigarettes? ___ Yes ___ No How many per day? _____
Do you drink (circle) beer/wine/liquor? How many per day/week/month? _____ ___ No
Have you used any illegal or addictive drugs? ___Yes ___ No Type: _____

WOMEN ONLY – PREGNANCY HISTORY Indicate quantity in the box:

Total pregnancies		Full Term		Premature		Induced abortion	
Spontaneous abortion		Ectopic		Multiple Birth		Living	

Date of last menstrual period _____