PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

NAME_____ SOCIAL SECURITY #_____
BIRTHDATE _____HOME PHONE _____WORK PHONE_____
ADDRESS_____CITY_____STATE_____ZIP_____

Check appropriate box: ☐MALE ☐FEMALE
Patient's or parent's employer_____
Business address _____City_____ State_____ Zip_____
Spouse or parent's name_____ Employer_____ Work phone_____
If patient is a student, name of school/college_____ City_____ State_____
Whom may we thank for referring you?_____
Person to contact in case of emergency_____ phone_____

INSURANCE INFORMATION

Name of insured_____ Relationship to patient_____
Birthdate_____ Social Security Number_____
Name of employer_____Work phone_____
Address of employer _____City_____ State_____ Zip_____
Insurance company_____ ID#_____Group#_____
Ins. Co. address_____ City _____State_____ Zip

Do you have additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured_____ Relationship to patient_____
Birth date_____ Social Security Number_____
Name of employer_____Work phone_____
Address of employer_____ City _____State_____ Zip_____
Insurance company_____ ID#_____ Group#_____
Ins.Co.address_____ City_____ State_____Zip_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to James R. Bollinger, M.D., P.C. for any services furnished to me by that physician. 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 payable for related services.

I hereby authorize medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security act.

MEDIGAP

I request that payment of authorized Medigap benefits be made either to me or on my behalf to James R. Bollinger, M.D.,P.C. for any services furnished by that physician/supplier. I authorize any holder of medical information about me to release to my insurance any information needed to determine these benefits payable for related services.

COMMERCIAL AUTHORIZATION

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor, unless paid for at the time service is rendered.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED BY PHYSICIAN WHETHER OR NOT COVERED BY INSURANCE.

Signature of patient or parent if minor_____ Date_____

PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

TODAY'S DATE____/____/____ DATE OF LAST PHYSICAL EXAM____/____/____

LAST NAME_____ FIRST NAME_____ MIDDLE_____

Social Security No. _____ DATE OF BIRTH____/____/____

CHIEF COMPLAINT

What is the main reason for your visit today? (Describe your problem in detail)

_____

_____

_____

History of Present Illness

Please answer the following questions

Location of the problem

Front Back

Abdomen Back Leg

Other_____

_____

_____

On a Scale of 1-10, with 10 being the most severe, circle the number that best describes the problem?

1 2 3 4 5 6 7 8 9 10

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other_____

Does anything help or make the problem worse?

Moving around Standing Up Lying on my side

Other_____

How long does the problem last?

30 minutes 1 hour It is always there

Other_____

Is anything else occurring at the same time?

YES No If yes, please explain.

Nausea Rash Headaches

Other_____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves Always there

Other_____

Does the problem interfere with your normal functions?

YES No If yes, please explain_____

_____

Physician use only: (Comments/Notes)

# Answers	Level of Service
1 - 3	1 or 2
4+	3 - 5

Past Medical & Social History

List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, breast cancer, heart disease, etc.,)

_____ _____ _____

_____ _____ _____

_____ _____ _____

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery Date

_____

_____

_____

Do you smoke? Y N

If yes, how much? _____

Do you drink? Y N

If yes, how much? _____

Are you on any medications? Y N (If yes, list all.)

_____ _____

_____ _____

Are you on a special diet? Y N (If yes, please explain)

_____

Do you have allergies? Y N (If yes, Please explain.)

_____

_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0	1 or 2
1 - 2	3
3	4 or 5

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Yes or No.

Please explain any Yes answers in space provided

Constitutional Symptoms
- Fever Y N
- Chills Y N
- Headache Y N
- Other_____

Eyes
- Blurred vision Y N
- Double vision Y N
- Pain Y N
- Other_____

Allergic/Immunologic
- Hay Fever Y N
- Drug allergies Y N
- Other_____

Neurological
- Tremors Y N
- Dizzy spells Y N
- Numbness/tingling Y N
- Other_____

Endocrine
- Excessive thirst Y N
- Too hot/cold Y N
- Tired/sluggish Y N
- Other_____

Gastrointestinal
- Abdominal pain Y N
- Nausea/vomiting Y N
- Indigestion/heartburn Y N
- Other_____

Cardiovascular
- Chest pain Y N
- Varicose veins Y N
- High blood pressure Y N
- Other_____

Integumentary
- Skin rash Y N
- Boils Y N
- Persistent itch Y N
- Other_____

Musculoskeletal
- Joint pain Y N
- Neck pain Y N
- Back pain Y N
- Other_____

Ear/Nose/Throat/Mouth
- Ear infection Y N
- Sore throat Y N
- Sinus problems Y N
- Other_____

Genitourinary
- Urine retention Y N
- Painful urination Y N
- Urinary frequency Y N
- Other_____

Respiratory
- Wheezing Y N
- Frequent cough Y N
- Shortness of breath Y N
- Other_____

Hematologic/Lymphatic
- Swollen glands Y N
- Blood clotting problem Y N
- Other_____

Psychologic
- Are you generally satisfied with your life? Y N
- Do you feel severely depressed? Y N
- Have you considered suicide? Y N
- Other_____

Physician use only: (Comments/Notes)

#Answer	Level of Service
0 - 1	1 or 2
2 - 9	3
10+	4 or 5

Physician:_____ Date: ____/____/____