SOUTHEASTERN OHIO PHYSICIANS. INC.

DRS. SARAP & LESLIE

WELCOME TO OUR PRACTICE

PATIENT NAME_____ **SS#**_____

Last first mi

DOB_____ **Age**____ **MARITAL STATUS:** *S M W D Sep*

ADDRESS_____

Street & PO Box City ST Zip

PHONE ( )_____ **WORK/2ND DAYTIME #**_____

MAY WE LEAVE NORMAL REPORTS AND MESSAGES ON YOUR MACHINE? Yes No

DO YOU HAVE RESTRICTIONS ON WHO RECEIVES YOUR MESSAGES? Yes No

EMERGENCY CONTACT NAME AND PHONE#_____

Someone other than one living with you

PATIENT MAIDEN and FORMER MARRIED NAMES_____

PATIENT EMPLOYER_____ **OCCUPATION**_____

SPOUSE or PARENT INFORMATION: NAME_____

SS#_____ **DOB**_____ **EMPLOYER**_____

PERSON RESPONSIBLE FOR PAYMENT IF NOT THE PATIENT_____

ADDRESS_____ **PHONE**_____ **RELATION**_____

PLEASE GIVE US A COPY OF ALL YOUR CURRENT INSURANCE CARDS

DOES THIS VISIT REQUIRE A REFERRAL BY YOUR INSURANCE CARRIER? Yes No

PRIMARY CARE PHYSICIAN_____

Out of town address

DID THIS PHYSICIAN REFER YOU HERE TODAY? YES NO **OTHER:**_____

REASON FOR TODAY'S VISIT_____

IF INJURED, HOW_____ **WHERE**_____

ACKNOWLEDGEMENTS WITH ASSIGNMENT OF BENEFITS:

- I acknowledge that I have received Southeastern Ohio Physicians' Notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.
- I authorize treatment for the above named patient.
- I understand that I am financially responsible for all charges whether or not paid by my insurance carrier AND my signature allows insurance payment be made directly to this practice.

SIGNATURE_____ **DATE**_____

please complete other side

HAVE YOU HAD ANY RECENT TESTING WHICH WOULD HELP IN YOUR TREATMENT TODAY? YES NO **LIST WITH DATES:** _____

_____

REVIEW OF SYSTEMS

Please Check

GOOD GENERAL HEALTH LATELY___	LOSS OF APPETITE_____	LEG/CALF PAIN_____
RECENT WEIGHT CHANGE_____	CHANGE IN BOWEL MOVEMENTS_____	VARICOSE VEINS_____
FEVER_____	NAUSEA OR VOMITING_____	PHLEBITIS_____
FATIGUE_____	FREQUENT DIARRHEA_____	ANEMIA_____
HEADACHES_____	CONSTIPATION/PAINFUL MOVEMENTS_____	BREAST PAIN_____
CHEST PAIN_____	RECTAL BLEEDING/BLOOD IN STOOL_____	BREAST LUMP_____
SHORTNESS OF BREATH_____	ABDOMINAL PAIN_____	BREAST DISCHARGE__

MEDICAL HISTORY

PRESENT MEDICATIONS: _____

DRUG ALLERGIES: _____

PRIOR SURGERIES: _____

MEDICAL PROBLEMS TREATED IN PAST: _____

_____

FAMILY HISTORY OF: DIABETES? YES NO **HEART DISEASE?** YES NO **TUBERCULOSIS?** YES NO

ANEURYSM? YES NO **CANCER?** YES NO **WHAT TYPES** _____

HAVE WE TREATED ANY MEMBER OF YOUR FAMILY? _____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION TO SOUTHEASTERN OHIO PHYSICIANS, INC TO BE USED FOR THE PURPOSE OF MY CONTINUED MEDICAL CARE AS DESCRIBED IN THEIR PRIVACY POLICY NOTICE.
I UNDERSTAND I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING WRITTEN NOTIFICATION TO SOUTHEASTERN OHIO PHYSICIANS, INC.

SIGNATURE_____ DOB_____ DATE_____

PRINTED NAME_____ WITNESS_____