CUMBERLAND FAMILY CARE, PC
Patient Information/Consent for Treatment, Payment, and Daily Operations (please print)

Name____Date_________________
Last First Middle

Address_____________________________________ City ___________________ Zip_________________

Date of Birth __________________________ Age __________ SS #______________________________

Home Phone:_______________________________ Cell Phone:____________________________________

Pharmacy(be specific) ____

Please Circle One for 1-4 below:

1. Race: (White) (Black) (Hispanic) (Other)____________________
2. Is English You Primary Language: (Yes) or (No)_______________
3. Sex: (Male) (Female)
4. Marital Status: (Single) (Married) (Divorced) (Widowed) (Other)_____________

E-mail address: ____

Insurance Plan Information
Please present card at reception
Person responsible for the bill if other than information provided above:

Name_____________________________________Relationship_____________________________

Address____Phone____________________________

Emergency Contact Information

Name____ Relationship to patient___________________

Phone:______________________ Cell _____________________ Work _________________________

Authorizations

I understand that I am financially responsible for services rendered by the physician and his staff regardless of insurance, including reasonable attorney's fees and costs of collection in the event of default. I authorize my insurance company to pay benefits directly to the physician. **If applicable: I give consent** for the above patient, who is either under the age of 18 or requires a legal custodian, to receive any treatment that is deemed necessary by Cumberland Family Care, PC. **I understand all of the above** and hereby state that the information is correct to the best of my knowledge. These authorizations apply to all occasions until revoked. My signature indicates that I have read the above and grant to request of authorizations. I give my consent for disclosure of my protected health information for purposes of treatment, payment, daily operations and other disclosures as specifically listed on the Notice of Privacy Practices posted in the lobby of Cumberland Family Care, PC.

Signature____ **Date**__________________________

Adult Past Medical History

Please Print All Information Neatly

Name:____ Date:_______________

Major/Chronic Illness: Check any major diseases you have as listed below:

	Coronary Artery Disease		Diabetes		High Cholesterol
	Heart Attack		High Blood Pressure		Asthma
	Congestive Heart Failure		Cancer (Type:____________)		Kidney Failure
	Pulmonary Illness (COPD)				

____

____

Other Illnesses: Indicate all other illnesses you have had.

____

____

____

Injuries: Have you had any of the following:

Broken/cracked bones (give bone and date):_______________________________________

Severe sprain/dislocation (give joint and date):____________________________________

Concussion, head injury/loss of consciousness:_____________________________________

Surgeries: List all operations or surgeries (tonsils, appendix, hysterectomy, gallbladder etc) and dates:

____

____

Hospitalizations: Have you ever been hospitalized for any illness? Give dates and details:

____

____

Previous Medical Specialists:____

Adult Past Medical History (cont.)

Women Only

Age at first period:___________ Age at menopause:___________

Abnormalities (paps/periods):____

Type of birth control uses:____

Number of pregnancies:_____ Pregnancy Complications:___________________________

Number of Children:_____

Year of Birth(s)	Type(s) of Birth(s) – Vaginal or C-section

Adult Social History

Tobacco:______________________ Alcohol/Drugs:______________________

Caffeine:______________________ Exercise:____________________________

Occupation:___________________ Education Level:_____________________

Marital Status:_________________ Lives with:___________________________

Religion:_______________________ Congreation/Church:________________

Living Will/Durable Power of Attorney: _____Yes _____No

(If yes, please provide a copy for our office chart)

Family Medical History

- ○ Adopted

(Please fill in with age of onset for each family member)

Family Name (Please Circle Status)	Date of Birth	Heart Attack	Mental Illness	Seizures	Cancer (Specify Type)	Diabetes	High Blood Pressure	Stroke	High Cholesterol	Alcohol/ Drug Abuse	Other (Please Specify)
Mother: Living / Deceased											
Father: Living / Deceased											
Sibling: Living / Deceased											
Sibling: Living / Deceased											
Sibling/Other: Living / Deceased											
Sibling/Other: Living / Deceased											
Other (Please Specify):											
Other (Please Specify):											
Other (Please Specify):											
Other (Please Specify):											

Medications

Medication Allergies:____

Pharmacy:_______________________________

Medication: Please list medication you currently take regularly (including over the counter meds and supplements.

Name	Dosage (mg)	# Pill Per Dose	# Doses Daily	Reason for Taking Medication

Reviewed 01.01.16