Trinity Fami[illegible]edical Center

Stephen E. Young, D.O.

Health "Care" for the Body, Mind and Spirit

Patient Demographic & Insurance Information

Basic Patient Information

Patient's Social Security Number: _____

Name of Patient _____
First Middle Last

Birth Date _____ **Gender** F M

Street Address _____

City _____ **State** _____ **Zip** _____

Home Phone (_____) _____ **Work Phone** (_____) _____

Patient's Relationship to Insured?

☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other_____

Please present your insurance card to the front desk receptionist when returning this form

Billing Information/Responsible Party/Guarantor for Encounter

Name of Insured _____
First Middle Last

Street Address _____

City _____ **State** _____ **Zip** _____

Birth Date _____ **Guarantor's Social Security Number:** _____

Gender F M

Home Phone (_____) _____ **Work Phone** (_____) _____

Guarantor's Employer _____

Insurance Coverage - Primary

Name of Insurance _____

Policy Number _____ **Effective Date:** (if applicable) _____

Group Number _____

Primary Care Physician _____

Name of Insured _____
First Middle Last

Birth Date _____ **Retire Date** (if applicable) _____

Gender F M **Phone** (_____) _____

Name of Insured's Employer _____

Address of Insurance Holder _____

(If different than Patient Address) _____

City _____ **State** _____ **Zip** _____

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Patient Demographic & Financial Responsibility Acknowledgement

Insurance Coverage - Secondary

Name of Insurance _____

Policy Number _____ **Effective Date:** _____

Group Name _____ **Expiration Date:** _____

Primary Care Physician _____

Name of Insured _____

First Middle Last

Birth Date _____ **Retire Date** (if applicable) _____

Gender **F** **M** **Phone** ( ) _____

Name of Insured's Employer _____

Address of Insurance Holder _____

(If different from Patient Address) _____

City _____ **State** _____ **Zip** _____

Additional Patient Information

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated

Patient's Employment Status ☐ Full-Time ☐ Part-Time ☐ None

Spouse's Employment Status ☐ Full-Time ☐ Part-Time ☐ None

Student Status (If Applicable) ☐ Full-Time ☐ Part-Time ☐ None

Did you bring with you today the written referral form from your Referring Physician? ☐ YES ☐ NO

Referral Physician _____

Emergency Contact Information - Primary Contact

Name _____ **Relationship to patient** _____

Home Phone ( ) _____ **Work Phone** ( ) _____

Street Address _____

City _____ **State** _____ **Zip** _____

Notes/Special Directions _____

Financial Responsibility Agreement

I/We hereby authorize Trinity Family Medical Center to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment of medical benefits to Trinity Family Medical Center and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize Trinity Family Medical Center to act on my behalf in accessing hospital medical records when and if needed.

_____ _____

Date **Patient or Guardian Signature**

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Patient Medical History

Patient Name: _____

Patient Age: _____ **Birth Date:** _____

Height: _____ **Weight:** _____ **BMI:** _____ **Frame:** _____

DESCRIBE YOUR PROBLEM OR INJURY:

Date of onset of the problem: _____ Name of Primary Care Physician: _____

Name(s) of Other Physician(s) you are currently seeing: _____

PAST MEDICAL HISTORY

Please list all previous operations

Surgery	Approximate Date of Surgery	Name of Surgeon	Hospital Where Performed

Past Major Medical Problems:

Please check if you are currently receiving treatment or have received treatment in the past for any of the following conditions:

- ❑ Anemia
- ❑ Arthritis
- ❑ Currently Pregnant
- ❑ Stroke
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Recurrent Infections
- ❑ Asthma
- ❑ Kidney Disease
- ❑ Phlebitis (blood clots)
- ❑ Thyroid Disease
- ❑ Ulcers
- ❑ Scarlet Fever
- ❑ Sexually Transmitted Diseases
- ❑ Birth Defects
- ❑ Rheumatic Fever
- ❑ Intestinal Disorders
- ❑ Other (Please Specify) _____

MEDICATIONS

Are you taking any prescriptions or over-the-counter medications? ❑ YES ❑ NO

If yes, please list medications below:

Medication	Dosage	How long have you been taking this medication?	Name of Prescribing Physician

DRUG ALLERGIES

Please list any drugs/substances to which you have had a reaction, and describe your physical reaction

Drug/Substance	Physical Reaction