



**INSURANCE INFORMATION**

**Primary insurance** \_\_\_\_\_ Preferred Plan (PPO): Yes No  
(Please provide card to receptionist for a photo copy)

Name of Subscriber (Who has the insurance?): \_\_\_\_\_

Soc. Sec # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Co-pay: Yes No

Individual ID #: \_\_\_\_\_ Group # and/or Name: \_\_\_\_\_

**Secondary insurance** \_\_\_\_\_ Preferred Plan (PPO): Yes No  
(Please provide card to receptionist for a photo copy)

Name of Subscriber (Who has the insurance?): \_\_\_\_\_

Soc. Sec # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Co-pay: Yes No

Individual ID #: \_\_\_\_\_ Group # and/or Name: \_\_\_\_\_

Photo copies of insurance cards go here

Consent for Care: I give permission and authorize the providers and staff of Greenlake Place PC PS, Inc. to examine and treat me.

Insurance Release of Benefits and Information: I authorize insurance benefits to be paid directly to the provider or clinic. I am financially responsible for any co-payments, deductibles, balances due, and charges for services not covered by my insurance plan. I authorize the providers or insurance company to release any information required for processing of insurance claims. This authorization is in effect until rescinded in writing.

Date: \_\_\_\_\_ Signature of Patient/Guardian: \_\_\_\_\_

**HEALTH HISTORY FORM**

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

MAJOR HEALTH CONCERNS:

- 1.
- 2.
- 3.

Please list surgeries, hospital stays, injuries or fractures. Continue on back if needed.  
DATE – ILLNESS or OPERATION-WHAT HOSP.

List all current meds. Include BCPs, shots, herbs, vits, skin & eye meds. Continue on back if needed.  
MEDICATION - DOSAGE - REASON

ALLERGIES Please circle if you are allergic to:

- Penicillin, sulfa, other Abx
- Codeine, morphine or narcotics
- Novacaine or other anesthetics
- Iodine, tape, eggs, Immunizations

Other allergies & med intolerances \_\_\_\_\_

Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_  
Age you began \_\_\_\_\_ Age(s) you quit \_\_\_\_\_  
How much alcohol per day, per week \_\_\_\_\_  
How much coffee or caffeine \_\_\_\_\_  
Recreational Drugs ? \_\_\_\_\_ Special diet? \_\_\_\_\_  
What exercise? \_\_\_\_\_  
Occupation? \_\_\_\_\_  
Foreign travel? \_\_\_\_\_

FAMILY HISTORY Please list parents, brothers, sisters, children

Any relatives with:

Relative Yr. born Health problems. Cause and date of death  
Mother \_\_\_\_\_  
Father \_\_\_\_\_

Hypertension \_\_\_\_\_  
Heart Disease \_\_\_\_\_  
Diabetes \_\_\_\_\_  
Cancer \_\_\_\_\_  
breast, colon \_\_\_\_\_  
Mental illness \_\_\_\_\_  
Alcoholism \_\_\_\_\_

REVIEW OF SYSTEMS: Circle any problems. Mark (C) if current. Mark (X) if past, and your age then

- \_\_\_\_\_ Eye or vision problems, glaucoma
- \_\_\_\_\_ Ear pain, infections, hearing problems
- \_\_\_\_\_ Hay fever, sinusitis, sore throat
- \_\_\_\_\_ Teeth or gum problems, dentures
- \_\_\_\_\_ Chest pain, heart palpitations, murmur
- \_\_\_\_\_ Short of breath, esp. lying flat or walking
- \_\_\_\_\_ Ankle swelling, fluid retention
- \_\_\_\_\_ Cough, wheezing, asthma, TB exposure
- \_\_\_\_\_ Problems with appetite, swallowing, gas
- \_\_\_\_\_ Heartburn, abdominal pain, hemorrhoids
- \_\_\_\_\_ Digestion, diarrhea, constipation, black stools
- \_\_\_\_\_ Jaundice, hepatitis, gallstones, ulcers
- \_\_\_\_\_ Bladder infections, kidney stones
- \_\_\_\_\_ Urinary incontinence or retention
- \_\_\_\_\_ Thyroid or blood sugar problems
- \_\_\_\_\_ Anemia, phlebitis of legs, transfusion
- \_\_\_\_\_ Skin rashes, itching, hives, warts, moles
- \_\_\_\_\_ Back aches, joint pains, headaches
- \_\_\_\_\_ Tremor, seizures, dizziness, fainting
- \_\_\_\_\_ Difficulty walking, weakness

- \_\_\_\_\_ Insomnia, sleepiness
- \_\_\_\_\_ Fatigue, fevers, night sweats
- \_\_\_\_\_ Weight loss, weight gain
- \_\_\_\_\_ Change in home, job, family in past year or illness or death of family or friends
- \_\_\_\_\_ Depression, or mental disorders
- \_\_\_\_\_ Drug or alcohol abuse, eating disorder
- \_\_\_\_\_ Stress. Anxiety, panic
- \_\_\_\_\_ Practicing safe sex; sexual problems
- \_\_\_\_\_ Orientation: Hetero, Gay, Lesbian, BI
- \_\_\_\_\_ Gonorrhea, Chlamydia, Herpes, Warts
- FOR WOMEN ONLY
- \_\_\_\_\_ Breast tenderness, lumps, discharge
- \_\_\_\_\_ Periods irregular, heavy, painful
- \_\_\_\_\_ Used birth control pills, diaphragm, IUD
- \_\_\_\_\_ Abnormal Pap(s), vaginal discharge, odor
- \_\_\_\_\_ Hot flashes Age at menopause \_\_\_\_\_
- Periods start every \_\_\_\_\_ days
- Days of flow \_\_\_\_\_ Age of onset \_\_\_\_\_
- Number of Pregnancies. \_\_\_\_\_ Miscarriages. \_\_\_\_\_ Births \_\_\_\_\_