FAMILY CARE CENTER

"Exercise is Medicine"

To help us meet all of your healthcare needs, please fill out this form completely. If you have any questions or need assistance please ask us and we will be happy to help.

Patient Information

Name: _____ DOB: _____

Social Security#: _____-_____-_____ Driver's License #: _____-_____-_____-_____

Ethnicity (Circle one): Hispanic or Non-Hispanic

Race: (Circle all that apply) White/Caucasian Black/African American Asian American-Indian Pacific Islander Hispanic Other: _____

Are you a Veteran? (circle one) Yes No

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Employer: _____ Phone: _____

Employment Status: (Circle one) Full Time Part Time Unemployed Self Employed

Marital Status: (Circle One) Minor Single Married Divorced Widowed

Emergency Contact: _____ Phone: _____

IF MINOR:

Mother's Name: _____ Phone: _____

Mothers DOB: _____

Fathers Name: _____ Phone: _____

Fathers DOB: _____

Scott A. Carlson, DO • Jill Schmidt, PA-C • Caitlin Greene, PA-C
1525 E. Beltline, Suite 102 • Grand Rapids, MI 49525 • (616) 363-0055 • Fax: (616) 363-5180
family-care-center.com

PLEASE LIST ALL MEDICATIONS YOU ARE NOW TAKING (including vitamins and OTC)

_____

_____

_____

PLEASE ANSWER THE FOLLOWING:

Are you under another physicians care? Y or N If yes please explain: _____
Have you ever been hospitalized or had major surgery: Y or N If yes please explain: _____
Have you ever had a serious head or neck injury? Y or N If yes please explain: _____
Are you on a special diet? Y or N If yes please explain:_____
Do you drink alcohol? Y or N If yes please explain: _____
Do you use tobacco? Y or N If yes please explain: _____
Do you use any controlled substances? Y or N If yes please explain:_____
Do you use any illegal substances? Y or N If yes please explain:_____

WOMEN ONLY
Are you pregnant/trying to get pregnant? Y or N
Are you taking Oral Contraceptives? Y or N
Nursing? Y or N

Are you allergic to any of the following medications/materials? Aspirin Penicillin Codeine Sulfa Metal Latex Iodine Local Anesthetics Barbiturates Acrylic Other: _____

Childhood Illnesses (Circle all that apply) Chicken Pox Rheumatic Fever Measles Mumps Scarlet Fever Other: _____

Authorization and Release

I certify that I read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Family Care Center to release any information including the diagnosis and records of any treatment or examination rendered to me (or my minor child) during the period of such medical care to the third party payers and or health practioners. I authorize and and request my insurance company to pay directly to Family Care Center. I understand that my medical insurance may pay less than the actual bill for services and agree to be responsible for payment of all services provided to me or my dependents.

_____ _____

Signature of patient or legal guardian if minor Date