PATIENT DEMOGRAPHICS

Patient Information

Last Name	First Name	Middle Name	Suffix	Social Security #

Gender (check)	Date of Birth	Marital Status (check)	Primary Care Physician
☐ M ☐ F		☐ Divorced ☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Other: _____	

Preferred Language (check)	Race (check)	Ethnicity (check)
☐ English ☐ Spanish _____	☐ Asian ☐ Black ☐ White ☐ Other: _____	☐ Hispanic ☐ Not Hispanic ☐ Unknown

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Email Address	How did you hear about us?	Referring Physician

Responsible Party

Check if same as: ☐ Patient

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Responsible Party?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Employer Information

Employer	Address	City / State	Zipcode

Emergency Contact

Check if same as: ☐ Responsible Party

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Emergency Contact?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Guardian Contact

Check if same as: ☐ Responsible Party ☐ Emergency Contact

Last Name	First Name	Gender (check)	Date of Birth	What is Patient's Relationship to Guardian?
		☐ M ☐ F		

Mailing Address	Apt / Lot	City / State	Zipcode	Phone #s
				Home ( ) Mobile ( ) Work ( )

Insurance Information

Check if: ☐ **Self Pay**

Check if same as: ☐ Responsible Party			Check if same as: ☐ Responsible Party		
Subscriber / Member Name		Date of Birth	Subscriber / Member Name		Date of Birth
What is Patient's Relationship to Subscriber?		Gender (check) ☐ M ☐ F	What is Patient's Relationship to Subscriber?		Gender (check) ☐ M ☐ F
Primary Insurance Company		Begin Date	Secondary Insurance Company		Begin Date
Insurance Mailing Address	City / State	Zipcode	Insurance Mailing Address	City / State	Zipcode
Subscriber / Member #	Group #		Subscriber / Member #	Group #	

Patient/Legal Guardian Signature **Date**

Patient/Legal Guardian Print

Wellington Regional Primary Care

Name:_____ DOB: _____

Reason for visit: _____

Preferred Pharmacy (Name/Location):_____

DO YOU HAVE ANY ALLERGIES: _____

List of Medications **CURRENTLY** taking (prescribed, over the counter and vitamins):

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often: _____

Name:_____Strength:_____How Often:

_____ If you have additional medications please list on back of form.

Medical History (mark ALL that apply):

- ☐ ADD
- ☐ ADHD
- ☐ Anemia
- ☐ Angina
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bipolar Disorder
- ☐ Bladder Cancer
- ☐ Bowel Problems
- ☐ Breast Cancer
- ☐ Breathing Difficulties
- ☐ Cancer (type): _____
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ GERD
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis (A, B, or C)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Liver Problems
- ☐ Lung Cancer
- ☐ Migraines
- ☐ Osteoarthritis
- ☐ Pancreatic Cancer
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Polymyalgia
- ☐ Prostate Cancer
- ☐ Psoriasis
- ☐ Psychiatric Problems
- ☐ Pulmonary Embolism
- ☐ Rectal Cancer
- ☐ Rheumatoid Arthritis
- ☐ Rosacea
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Sjogren Syndrome
- ☐ Stroke / CVA
- ☐ Other: _____

_____

_____

Surgical / Procedures (mark ALL that apply):

- ☐ ACL Surgery / Reconstruction
- ☐ Adenoids removed
- ☐ Appendix removal
- ☐ Back Surgery
- ☐ Breast Augmentation
- ☐ Cardiac Bypass Surgery
- ☐ Cardiac Catheterization
- ☐ Cataract Surgery
- ☐ Colon resection
- ☐ Colostomy / Reversal
- ☐ C-Section
- ☐ D&C (Dilation & Curettage)
- ☐ Defibrillator Implant

Name:_____ DOB: _____

☐ Gallbladder removal	☐ Lumpectomy	☐ Pacemaker
☐ Hip replacement	☐ Lymph node biopsy	☐ PTCA (Angioplasty)
☐ Knee replacement	☐ Mastectomy	☐ Shoulder Surgery
☐ Splenectomy	☐ Tubal Ligation	☐ Other not listed:
☐ Tonsils removed	☐ Vasectomy	_____
☐ Total Joint replacement		_____

Women's Health:

	Date	Results	
Last menstrual period	_____	☐ Normal	☐ Abnormal
Pap / Pelvic Exam	_____	☐ Normal	☐ Abnormal
Last Mammogram	_____	☐ Normal	☐ Abnormal
Bone Density	_____	☐ Normal	☐ Abnormal

Number of Pregnancies:_____ Deliveries:_____ Miscarriages:_____ Abortions: _____

Health Maintenance:

	Date	Results	
Physical Exam/Wellness Visit	_____	☐ Normal	☐ Abnormal
Cholesterol	_____	☐ Normal	☐ Abnormal
Colonoscopy	_____	☐ Normal	☐ Abnormal
EGD	_____	☐ Normal	☐ Abnormal
Prostate / PSA	_____	☐ Normal	☐ Abnormal
Stress Test / Nuclear Stress Test	_____	☐ Normal	☐ Abnormal

Immunizations:

	Month / Year		
Hepatitis A	#1_____	#2 _____	
Hepatitis B	#1_____	#2_____	#3 _____
Gardasil (HPV)	#1_____	#2_____	#3 _____
Influenza	_____	Pneumonia	_____
Tetanus	_____	Zostavax (Shingles)	_____
TB Skin Test	_____	Chicken Pox	_____

Social History:

Smoker: ☐ Never ☐ Formerly ☐ Currently

If YES, mark ALL that apply: ☐ Cigarettes ☐ Cigars ☐ Chewing/Dipping Tobacco ☐ Electronic Cigarettes

How much per day:_____ How many years:_____ Quit Date: _____

Name:_____ DOB: _____

Alcohol use: ☐ Never ☐ Daily ☐ Social Estimated daily consumption: _____

Are you sexually active? ☐ Yes ☐ No
Are you using a form of birth control? ☐ Yes ☐ No If yes, type: _____

Have you ever had a STD? ☐ Yes ☐ No If yes, type: _____

Street drug use: ☐ Never ☐ Previous ☐ Currently Type of Drug(s): _____
Do you feel safe at home? ☐ Yes ☐ No

Living Will / POA: Do you have a living will? ☐ Yes ☐ No
Do you have Durable Power of Attorney for healthcare? ☐ Yes ☐ No

---

Family History: ☐ Adopted ☐ Unknown

Mother Living: ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

Father Living: ☐ Yes ☐ No Age of Death: _____ Cause of Death: _____

(Please list any serious medical history that runs in your family)

Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent

---

Provider List: (Physician/Practice Name)

Cardiologist:_____ Gastroenterologist:_____

General Surgeon: _____ Neurologist_____

OBGYN: _____ Urologist: _____

Other: _____

Hospital Admission(s) / ER Visit(s): Year Diagnosis

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____