Baylor Scott & White
HILLCREST INTERNAL MEDICINE AND SENIOR HEALTH CENTER
WACO

Patient:

Patient's Name: _____ Sex: Male Female

Home Address: _____ Marital Status: Married Single Divorced Widowed

City: _____ Employment Status: Employed Unemployed Retired Student

State: _____ Zip:_____ Patient's Employer/School:_____

Home phone: (____)_____ IF MARRIED: Spouse's Name: _____

Cell phone: (____)_____ Phone: (____)_____

Work phone: (____)_____

Date of Birth: _____ Age: _____

Social Security No.: _____ Email address: _____

Emergency Contact (other than spouse):

Name: _____Relationship: _____ Ph: _____

Name: _____Relationship: _____ Ph: _____

Guarantor (who is responsible for the bills and where they will be sent):

Name: _____ Sex: Male Female

Address: _____ Date of Birth: _____

City: _____ Relationship to Patient: _____

State: _____Zip: _____ Phone No.: _____

In order for us to file your insurance, the following MUST be complete. "INSURED" is who carries for the coverage.

Primary Insurance Information:

Insurance Company Name: _____ Id No.: _____Group No.: _____

Primary Insured Name: _____ Sex: Male Female

Primary Insured address: _____ Insured's Date of Birth: _____

City: _____ Insured's Social Security No.: _____

State: _____ Zip: _____ Relationship to Patient: _____

Phone No.: _____ Insured's Employer: _____

Secondary Insurance Information:

Insurance Company Name _____ Id No.: _____Group No.: _____

Primary Insured Name _____ Sex: Male Female

Primary Insured address: _____ Insured's Date of Birth: _____

City: _____ Insured's Social Security No.: _____

State: _____Zip: _____ Relationship to Patient: _____

Phone No.: _____ Insured's Employer: _____

Patient Medical History

(circle all that you currently have and/or have previously had)

Heart Problems	Neurological	Psychological	Gastrointestinal
• Congestive Heart Failure • Deep Vein Thrombosis • Heart Attack • Heart Murmur • High Blood Pressure • High Cholesterol • Neuropathy • Irregular Heartbeat • Anemia/Clotting Disorder • Other:	• Alzheimer's disease • Parkinson's disease • Migraines • Seizure Disorder • Stroke • Dementia • TIA • Other	• Anxiety • Depression • Schizophrenia • Bipolar **Cancer** Type, stage &Location	• Cirrhosis • Gastric Ulcer • GERD (acid reflux) • Rectal Bleeding • Hemorrhoids • Diverticulitis • Crohn's Disease Ulcerative Colitis • Other:
Endocrine Problems	**Urinary Problems**	**Lung Problems**	**Musculoskeletal**
• Diabetes Type 1 (juvenile) • Diabetes Type II (Adult onset) • Hyper/hypothyroid disorder • Hyper/Hypocalcaemia • Other:	• Kidney Infection • Kidney Stones • Kidney Disease/Failure • Prostate Enlargement • Other:	• Asthma • COPD • Emphysema • Pneumonia • Pulmonary Embolism • Sleep Apnea • Allergies • Other:	• Osteoarthritis • Osteoporosis • Rheumatoid Arthritis **Infections:** Hepatitis B Hepatitis C HIV+

Family Medical History

Mother: _____

Father: _____

Maternal Grandmother: _____

Maternal Grandfather: _____

Paternal Grandmother: _____

Paternal Grandfather: _____

Siblings: _____

Children: _____

Surgical History **(Please list all surgeries, year performed and surgeon)**

_____

_____

_____

Social History

Marital Status: Number of Children: Occupation:

Female Patients ONLY:

Are You Pregnant? Y/N Date of Last Menstrual Period: Age of Menopause:

Substance Use (past and present)

Tobacco Y/N If Yes, Amount/week: _____ Age Started/Stopped: _____

Alcohol Y/N If Yes, Amount/week: _____ Age Started/Stopped: _____

Drugs Y/N If Yes, Amount/week: _____ Age Started/Stopped: _____

Medication List

Please include all prescriptions, over-the-counter, vitamins and herbal supplements

Medication Name	Dosage	Times Per Day	Reason

Preferred Pharmacy:

Allergies:

Circle if you are allergic to the following:

Penicillin Codeine Sulfa Drugs Latex Iodine

Please list any other foods and/or medications you are allergic to and your reaction to them:

Allergy	**Reaction**