William Newton
HILLSIDE
FAMILY MEDICINE

Welcome to our Clinic

Patient First Name	Middle Name	Last Name
Date of Birth	Pediatric	Social Security Number

Gender: Male Female	Race	Marital Status: S M W D Separated
Preferred Contact Method: Email Phone Postal Patient Portal	Appointment Notification Contact Method: Email Text Call: Primary Cell Work	Email

Street Address	City	State	Zip

Primary Phone #	Work Phone #	Mobile/Other Phone #

Emergency Contact Last Name, First Name	Relationship	Phone #

Guarantor Name		Patient's Relationship to Guarantor
Date Of Birth	Social Security #	Address
Primary Phone #	Work Phone #	Employer

Employer	Occupation	City, State, ZIP

Insurance Information	Secondary Insurance Name
Insurance Company:	Insurance Company:
Policy #:	Policy #
Subscriber Name:	Subscriber Name:
Subscriber DOB:	Subscriber DOB:
Please Check here if NO Insurance:	Please Check here if NO Insurance:

Patient Name	DOB	Peds	Age

PERSONAL MEDICAL HISTORY: PLEASE CIRCLE ALL THAT APPLY

ADHD	Behavior Problems	Learning Disabilities	
Allergies, Seasonal	Depression	Hepatitis	Sleep Apnea
Anemia	Diabetes: 1 or 2	Irritable Bowel Syndrome	Seizure Disorder
Anxiety	Eczema	Liver Disease	Thyroid Disorder
Asthma	GERD	Crohn's Disease	
Bladder Problems	Heart Disease	High Cholesterol	
Constipation	Hernia		**Other not listed:**
Headaches	Umbilical Hernia		
Kidney Disease	High Blood Pressure		

Allergies:

Drugs:
Food
Other: (bees, pets, etc.)

**IMMUNIZATIONS:

Please provide a copy of immunizations record.

Patient Name	DOB	Peds	Age

SURGICAL HISTORY: PLEASE LIST ALL PRIOR SURGERIES AND APPROXIMATE DATES PERFORMED:

Surgery	Date

HOSPITAL ADMISSIONS OR RECENT EMERGENCY ROOM VISITS THIS YEAR: Month / Year

SOCIAL HISTORY

13 + Years	Frequency
Tobacco Use	
Alcohol Use	
Drug Use	
Caffeine	
Exercise	

Medication	Dosage	Frequency

Patient Name	DOB	Peds	Age

Preferred Pharmacy:

Pharmacy Name:	**Address**	**Phone Number**

CULTURAL HISTORY:

Education Level	Elementary	High School	Vocational	College	Graduate/Professional

Do you have any vision problems that affect your communication?☐ Yes or ☐No

Do you have hearing problems that affect your communication?☐Yes or ☐No

Do you have any limitations to understanding and / or following instructions?☐ Yes or ☐No

Number of Children in the home:

List any family medical history:

Family History	Mother	Father	Siblings	Grandparents
Asthma				
Allergies				
Diabetes				
Heart Issues				
Other:				

Patient Name	DOB	Peds	Age

Authorization to release information:
I authorize for information regarding my medical care to be released to the following person(s) if he or she so requests:

Name	Relationship to patient	Phone number

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any information required for claim(s) submission to my insurance company(s). I also authorize that payments be made directly to Health Professionals of Winfield.

Signature: _____ Date: _____

Parent, if minor: _____ Date: _____