Patient Information Form

Amanda Nichols, MD
Gary Nichols, MD
Jason Snider, PA-C
Call: 304-447-2038

Rogelio Bantug, MD
Keith Poole, DO

Call 304-447-2030

Patient Information

Name (First, Middle, Last)	Date of Birth	Social Security Number	Sex
Mailing Address	City, State, & Zip		
Physical Address (if different than above)	City, State, & Zip		
Home Phone	Cell Phone		
Employer	Employer Address		
Work Phone	Marital Status: Single - Married - Separated - Divorced - Widowed		
Emergency Contact Name & Relationship	Name of Spouse		
Emergency Contact Phone			

If patient is a minor please complete the following:

Father's Name	Date of Birth	Social Security Number
Address (if different than patient)	Phone Number	
Mother's Name	Date of Birth	Social Security Number
Address (if different than patient)	Phone Number	

Insurance Information

Name of Insured (First, Middle, Last)	Date of Birth	Social Security Number	Sex
Mailing Address (if different than above)	Name of Insurance #1		
Physical Address (if different than above)	Identification Number		
Home Phone	Group Number		
Employer	Patient's Relationship to Insured		
Work Phone	Current PCP (listed on insurance card)		
Name of Insurance #2 (if applicable)	Identification Number		
Name of Insured (First, Middle, Last)	Group Number		
Mailing Address (if different than above)	Patient's Relationship to Insured		
Physical Address (if different than above)	Employer		
Home Phone	Work Phone		

I certify that the above information is true and correct to the best of my knowledge.
I understand and agree that I am ultimately responsible for payment.

Signature of Person Financially Responsible Date

Health History Form

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Susan Carr, FNP-BC
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Name (First, Middle, Last)	Date of Birth	Social Security Number	Sex
Address	City, State, & Zip		

What is the reason for your visit today?

Please list any chronic medical problems: (Diabetes, High Blood Pressure, depression, etc)	

Please list any acute problems from the past: (Heart Attack, Stroke, Hip Fracture, etc)	

Please list any current medications: (prescription, over-the-counter, herbal)	

Please list any medication or food allergies	

Please list any surgeries or hospitalizations (Dates if Possible)	

Please list any medical problems in each of the following family members:	
Mother:	Father:
Brothers/Sisters:	Children:
Please list any other family members with heart disease:	Please list any other family members with diabetes:
Please list any family members with cancer:	Other:

Health History Form (pg 2)

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When was your last TETANUS SHOT:	When was your last FLU SHOT:
When was your last CHOLESTREOL BLOOD TEST:	

FOR WOMEN	FOR MEN
Date of your last menstrual period:	Date of your last PSA:
Last Pap Smear:	Date of your last colonoscopy: (if over 50)
Last Breast Exam:	Date of your last stool card: (if over 50)
Last Mammogram:	Date of last rectal exam: (if over 50)

Do you smoke?	☐ YES	☐ NO	If yes…How many packs/day?			How many years?	
Do you use other tobacco products?	☐ YES	☐ NO	If yes…How much/day?			How many years?	
Do you use alcohol?	☐ YES	☐ NO	Rarely ☐	Occasionally ☐	Weekly ☐	Daily ☐	
Do you exercise?	☐ YES	☐ NO	Rarely ☐	Occasionally ☐	Weekly ☐	Daily ☐	
Please list type of exercise:							

Are you having any of the following symptoms?
(Plese circle the appropriate response)

Fever	YES	NO	Cough	YES	NO
Chills	YES	NO	Nausea	YES	NO
Weight Loss	YES	NO	Diarrhea	YES	NO
Visual Changes	YES	NO	Burning with Urination	YES	NO
Runny Nose	YES	NO	Joint Pain	YES	NO
Chest Discomfort	YES	NO	Numbness	YES	NO
Shortness of Breath	YES	NO	Rash	YES	NO

Health History Form
CHILD/ADOLESCENT

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Name (First, Middle, Last)	Date of Birth	Social Security Number	Sex
Address	City, State, & Zip		

What is the reason for your visit today?

Who was your previous Physician?

Please list any chronic medical problems: (Diabetes, High Blood Pressure, depression, etc)

Birth History: (please circle)

Vaginal Delivery ◯ Casesarian Section ◯	How many getational weeks at delivery?
If Caesarian what was the reason?	Did patient go home within 3 days of birth? ◯ YES ◯ NO

Immunizations

Are immunizations up to date? ◯ YES ◯ NO	(If older than 11) Have you had the following	
Have you ever had Chicken Pox? ◯ YES ◯ NO	Tdap YES NO	Menactra YES NO
When was your last seasonal flu shot?	Gardasil YES NO	Tetanus Booster YES NO

Please list any current medications: (prescription, over-the-counter, herbal)

Please list any medication or food allergies

Please list any surgeries or hospitalizations (Dates if Possible)

Please list any medical problems in each of the following family members:

Mother:	Father:
Brothers/Sisters:	Children:
Please list any other family members with heart disease:	Please list any other family members with diabetes:
Please list any family members with cancer:	Other:

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Does anyone in household smoke?	YES NO	If yes…How many packs/day?		How many years?
Do you smoke?	YES NO	If yes…How many packs/day?		How many years?
Do you use other tobacco products?	YES NO	If yes…How much/day?		How many years?
Do you use alcohol?	YES NO	Rarely	Occasionally Weekly	Daily
Do you exercise?	YES NO	Rarely	Occasionally Weekly	Daily
Please list type of exercise:				

Are you having any of the following symptoms?
(Plese circle the appropriate response)

Fever	YES	NO	Cough	YES	NO
Chills	YES	NO	Nausea	YES	NO
Weight Loss	YES	NO	Diarrhea	YES	NO
Visual Changes	YES	NO	Burning with Urination	YES	NO
Runny Nose	YES	NO	Joint Pain	YES	NO
Chest Discomfort	YES	NO	Numbness	YES	NO
Shortness of Breath	YES	NO	Rash	YES	NO