



EXPRESS FAMILY CLINIC

Health History Form

Patient Name: _____ DOB: _____ Date: _____

Reason for Visit: _____ New Primary Care Patient [] Urgent Care Only []

Allergy to Medicine & what happens? [] No known allergies

Medications	What happens?	Medications	What happens?

Current Medication including over the counter medicine [] No current meds

Medications	Dosage/Frequency	Medications	Dosage/Frequency

Past Medical History: Do you have any medical problems below? [] NO

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Migraine Headache |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD (Emphysema) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stomach Ulcer Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> TB/ Positive PPD |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Other _____ |

Past Surgical History: Have you ever had any surgeries? [] NO

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Carpal Tunnel Release | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Fracture Repair |
| <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Thyroid Removed |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Colon Resection | <input type="checkbox"/> LASIK | <input type="checkbox"/> Tonsil /Adenoid Removed |
| <input type="checkbox"/> Knee Scope | <input type="checkbox"/> Gallbladder Removed | <input type="checkbox"/> Liver Biopsy | <input type="checkbox"/> Back Surgery |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Prostate Removed | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Bowel Resection | <input type="checkbox"/> C-Section | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Breast Augmentation |
| <input type="checkbox"/> D and C | <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Fibroid Remove |
| <input type="checkbox"/> Others _____ | | | |

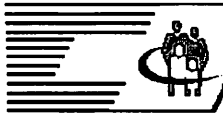
Family History: Has anyone in your family (mom, dad, brother, sister) have the following problem? [] NO

- | | | | |
|--|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke (CVA) | <input type="checkbox"/> Other _____ |

Social History: [] Tobacco: ___ pack/day [] Alcohol: ___ cans/week [] Drugs: _____

Female Only: [] N/A Date of Last Period: _____

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Are you pregnant? | <input type="checkbox"/> Are you nursing |
|------------------------------------|--|--|



EXPRESS FAMILY CLINIC

URGENT CARE & PRIMARY CARE

Patient Registration Information

PATIENT'S PERSONAL INFORMATION		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Name: _____		_____		_____	
Last name		First name		Middle	
Date of Birth: ____ / ____ / ____		Social Security #: ____ - ____ - ____			
Home Phone: (____) _____		Work Phone: (____) _____		Cell Phone: (____) _____	
Address: _____		Apt. #: ____	City: _____	State: ____	Zip: _____
PATIENT'S / RESPONSIBLE PARTY INFORMATION		Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			
Name: _____		_____		_____	
Last name		First name		Middle	
Date of Birth: ____ / ____ / ____		Social Security #: ____ - ____ - ____			
Home Phone: (____) _____		Work Phone: (____) _____		Cell Phone: (____) _____	
Address: _____		Apt. #: ____	City: _____	state: ____	Zip: _____
EMERGENCY CONTACT					
Name _____		Relationship: _____			
Home Phone: (____) _____		Work Phone: (____) _____		Cell Phone: (____) _____	

Assignment of Benefits • Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Total Family Care, LLC dba Express Family Clinic, Dr. Michelle Nguyen and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. _____(initial)

PAYMENT POLICY (SEE ATTACH)

I have read and accept Express Family Clinic payment policy. _____ (initial)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I hereby give my consent for Express Family Clinic to use and disclose protected health information (PHI) about me to carry out healthcare operations (i.e treatment, diagnostic procedures, and payment)

With this consent, Express Family Clinic may

[] call my home or cell and leave a message on voice mail or in person in reference to any item that assist the clinic in carrying out healthcare operation, such as appointment reminders, insurance information and any calls pertaining to my clinical care, including laboratory results among others.

[] release my Protected Health Information to:

Name: _____ Relationship: _____

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Express Family Clinic may decline to provide treatment to me.

I further agree that a photocopy of this agreement shall be as valid as the original.

Signature: _____ relationship to patient: _____ Date: _____