

Practitioners Community Care, LLC

**Welcome Information**

**COPAYMENTS –** Each visit, depending on an individual’s insurance plan, may require a

Co-payment. We accept cash and credit payments

**PRESCRIPTION REFILLS -** Please do not call when you have zero or only a few pills left.

Take inventory of your pills and make a list so when the Nurse Practitioner visits, all refills can be renewed all at once until the next visit. Please do not call for medication renewals on the weekend, your call will not be transferred until week day

**FORMS REQUIRED -** All new patients forms should be filled out prior to appointment for house calls. Please have a list of all medications on hand as well as all current insurance cards

**CURRENT INFORMATION –** Update your contact and medical information promptly. It is essential that we are notified immediately of insurance changes. Make certain all proxy information is established.

Practitioners Community Care, LLC

**New Patient Medical Information**

**Please complete this form to the best of your ability.**

**All information is strictly confidential.**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Security #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status (Circle applicable):**

Single Married Separate Divorced Widow(er)

**Who referred you to us?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Name of Primary Doctor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Doctor Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In Case of Emergency, Contact:**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Practitioners Community Care, LLC to provide medical

care to me in my home/office. I hereby authorize my insurance company if accepted by

Practitioners Community Care, LLC, to pay the proceeds directly to

Practitioner Community Care, LLC. If Practitioners Community Care, LLC does not accept my insurance, I agree to pay for services at the time of visit. If needed an itemized statement will be issued to the patient to submit to his/her insurance for reimbursement.

**Signature of Patient / Agent / Guardian:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Practitioners Community Care, LLC

**New Patient Medical History Information**

**Please complete this form to the best of your ability.**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Today’s Complaint (Circle all that apply):**

Headaches Diarrhea Cough Fever Injury

Blood pressure Pain Abdominal Pain Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe above complaint in detail:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What conditions have you had in the past or present? (Circle all that apply):**

High Blood Pressure High Cholesterol Allergies Heart Disease

Anemia Diabetes Fractures Asthma Pneumonia Cancer

Urinary Tract Infection Depression Anxiety Pressure Ulcers Stroke

Arthritis Thyroid Disease Osteoporosis Kidney Disease Dementia Smoker

**Other conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family history conditions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe past medical surgeries:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Describe allergies to medications / food and reaction:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Describe any past or present smoking / alcohol activities:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Preventive Care Information**

**Please complete this form to the best of your ability.**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE NOTE: Each line must be filled with year, never or not applicable.

|  |  |
| --- | --- |
| Exam | Year-Never-N/A |
| Annual Physical Exam |  |
| Complete Blood Work |  |
| A1C |  |
| Glucose |  |
| Prostate Exam |  |
| PAP |  |
| TD |  |
| Bone Density |  |
| Mammogram |  |
| AAA screen |  |
| Flu Immunization |  |
| Pneumonia Immunization |  |
| Breast Ca screen |  |
| EKG |  |
|  |  |
|  |  |