JFK Medical Associates

(Please Print)

Date: ____________________

Patient Information:

Name: ____ SS # ______________________________

Last name First Middle Initial

Address: ____ Cell Phone: (____) ____________________

City: ______________ State: ________ Zip: __________ Home Phone: (_____) ____________________

Sex: □ M □ F Age: __________ Birthdate: ______________ □Married □ Widowed □ Single □Minor

E-mail Address: ____ □Separated □ Divorced □ Partnered for____years

Patient Employer/School: ______________________________ Occupation: ______________________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ____________________ Phone: (______) __________________

Primary Insurance:

Person Responsible for Account: ____

Last name First Middle Initial

Relation to Patient: ____________ Birthdate: ______________ Soc. Sec #: ______________________________

Address (If different from patient's): ______________________________ Phone: (__) ______________________

City: ______________________ State: ______________________ Zip: ______________________

Person Responsible employed by: ______________________ Occupation: ______________________________

Business Address: ______________________________ Business Phone: (____) ____________________

Insurance Company: ____

Contract #: ____________________ Group #: ____________________ Subscriber #: ____________________

Names of other Dependents covered under this plan: ____

Additional Insurance:

Is patient covered by Additional Insurance? □Yes □No

Subscriber Name: __________________________ Relation to Patient: ______________________________

Address (If different from patient's): ______________________________ Phone: (__) ______________________

City: ______________________ State: ______________________ Zip: ______________________

Subscriber Employed by: ________________________ Business Phone: (____) ________________________

Insurance Company: ____________________________ Soc. Sec #: ______________________________

Contract #: ____________________ Group #: ____________________ Subscriber #: ____________________

Names of other Dependents covered under this plan: ____

Assignment Release:

I certify that I, ______________________________ and/or my dependent(s), have insurance coverage with
Patient Name

______________________________ And assign directly to Dr______________________ all insurance benefits, if any,
Name of Insurance Company(ies)

otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to above-names Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or on year from the date signed below.

Signature of Patient, Parent, Guardian, or Personal Representative ______________________ Date

______________________________ ______________________

Signature of Patient, Parent, Guardian, or Personal Representative ______________________ Relationship to Patient

Fill in health information about your immediate family.

Patient Name: ______________________________

Family History:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (V) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

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Hospitalizations:

Year	Hospital	Reason for Hospitalization & Outcome

Pregnancies:

Year of Birth	Sex of Birth	Complications (if any)

Occupational:

Check (√), if your exposes you to:

	Stress
	Heavy Lifting
	Hazardous Substances
	Other

Health Habits:

Check (√) if you use, than indicate how much you use it.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates ______________.

Serious Illness/ Injury	Date	Outcome

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

X ______________________________ Signature of Patient, Parent, Guardian or Personal Representative

______________________________ Date

______________________________ Please print name of Patient, Parent, Guardian, or Personal Representative

______________________________ Relationship to Patient

______________________________ Reviewed By

______________________________ Date

JFK Medical Associates

Confidential

Patient Name: ______________________________ **Today's Date:** ____________________

Age: ______ **Birthdate:** ______________________ **Date of last physical examination:** _________________

What is your reason for visit? ____

Symptoms – Check (√) symptoms you currently have or have had in the past year.

General
- □ Chills
- □ Depression
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Loss of Sleep
- □ Loss of Weight
- □ Nervousness
- □ Numbness
- □ Sweats

Gastrointestinal
- □ Appetite poor
- □ Bloating
- □ Bowel changes
- □ Constipation
- □ Diarrhea
- □ Excessive hunger
- □ Excessive thirst
- □ Gas
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Rectal bleeding
- □ Stomach pain
- □ Vomiting
- □ Vomiting blood

Eye, Ear, Nose, Throat
- □ Bleeding gums
- □ Blurred vision
- □ Crossed eyes
- □ Difficulty swallowing
- □ Double vision
- □ Earache
- □ Ear Discharge
- □ Hay fevers
- □ Hoarseness
- □ Loss of hearing
- □ Nosebleeds
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems
- □ Vision – Flashes
- □ Vision – Halos

MEN only
- □ Breast lump
- □ Erection difficulties
- □ Lump in testicles
- □ Penis discharge
- □ Sore on penis
- □ Other

WOMEN only
- □ Abnormal Pap Smear
- □ Bleeding between periods
- □ Breast Lump
- □ Extreme menstrual pain
- □ Hot flashes
- □ Nipple discharge
- □ Painful intercourse
- □ Vaginal discharge
- □ Other

Date of last menstrual period _______________
Date of last Pap Smear ____________________
Have you had a mammogram ______________
Are you pregnant ___ **Number of children** ____

CARDIOVASCULAR
- □ Chest Pain
- □ Irregular Heart Beat
- □ Poor Circulation
- □ Swelling of ankles
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Rapid Heart Beat
- □ Varicose veins

GENITO-URINARY
- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control
- □ Painful urination

MUSCLE/JOINT/BONE
Pain, Weakness, Numbness in:
- □ Arms
- □ Back
- □ Feet
- □ Hands
- □ Hips
- □ Legs
- □ Neck
- □ Shoulders

SKIN
- □ Bruises
- □ Itching
- □ Scars
- □ Sores that won't heal
- □ Hives
- □ Rash
- □ Changes in moles

Condition

Patient Name: ______________________________

Check (√) symptoms you currently have or have had in the past year.

- □ **AIDS**
- □ **Alcoholism**
- □ **Anemia**
- □ **Anorexia**
- □ **Appendicitis**
- □ **Arthritis**
- □ **Asthma**
- □ **Bleeding Disorders**
- □ **Breast Lump**
- □ **Bronchitis**
- □ **Bulimia**
- □ **Cancer**
- □ **Cataracts**
- □ **Chemical Dependency**
- □ **Chicken Pox**
- □ **Diabetes**
- □ **Emphysema**
- □ **Epilepsy**
- □ **Glaucoma**
- □ **Goiter**
- □ **Gonorrhea**
- □ **Gout**
- □ **Heart Disease**
- □ **Hepatitis**
- □ **Hernia**
- □ **Herpes**
- □ **High Cholesterol**
- □ **HIV Positive**
- □ **Kidney Disease**
- □ **Liver Disease**
- □ **Measles**
- □ **Migraine Headaches**
- □ **Miscarriage**
- □ **Mononucleosis**
- □ **Multiple Sclerosis**
- □ **Mumps**
- □ **Pacemaker**
- □ **Pneumonia**
- □ **Polio**
- □ **Prostate Problem**
- □ **Psychiatric Care**
- □ **Rheumatic Fever**
- □ **Scarlet Fever**
- □ **Stroke**
- □ **Suicide Attempt**
- □ **Thyroid Problems**
- □ **Tonsillitis**
- □ **Tuberculosis**
- □ **Typhoid**
- □ **Ulcers**
- □ **Vaginal Infections**
- □ **Venereal Disease**

Medications (List any medications you are currently taking)

____
____
____
____
____
____
____
____

Allergies

____
____
____
____
____

Pharmacy Name: ______________________________

Phone: ______________________________