Patient ID Label

HISTORY OF PRESENT ILLNESS

Is this problem work related? ☐ YES ☐ NO If yes, employer contact name/phone: _____

Describe in your own words the reason for your visit today: _____

_____

When did problem begin (Month/Date/Year)? _____ Body Part(s) affected _____ ☐ Right ☐ Left

How Did Injury Occur? _____

Related to your current problem:

Imaging/Study	Date	Place of Service
MRI		
CAT Scan		
X-Ray		
Bone Scan		
EMG		
Other:		

☐ None

WORK HISTORY:

☐ Presently working ☐ Disability (specify date): _____ ☐ Retired: _____

If working, list employer: _____ Job title: _____

Type of work/duties: _____

PATIENT INTAKE

Weight: _____ Height: _____

Check the appropriate answers below:

Do you currently drink alcohol? ..... ☐ Yes ☐ No If yes, how much? _____

Do you currently use any recreational drugs ..... ☐ Yes ☐ No If yes, what type? _____

Do you currently use tobacco? ..... ☐ Yes ☐ No If yes, how many packs per day? _____

Are you RIGHT or LEFT hand dominant? ..... ☐ Right ☐ Left

ALLERGIES

Are you allergic to any medications or latex? ..... ☐ Yes ☐ No If yes, please list: _____

Preferred Pharmacy: _____

MEDICATIONS - Prescribed by a non-IU Health Provider (Include prescriptions, over-the-counter medications, and vitamins.)

Please provide a list of all current medication: ☐ None ☐ Copy of medication list provided

Medication	Dosage	Medication	Dosage

Are you currently under a pain contract?..... ☐ Yes ☐ No If yes, with whom? _____

Are you currently taking blood thinner? ..... ☐ Yes ☐ No If yes, which one? _____

Patient ID Label

MEDICAL HISTORY

SELF-MEDICAL HISTORY: (Mark only those that apply to you.)

- ☐ None Apply
- ☐ Alcohol Abuse
- ☐ Alzheimer's Disease
- ☐ Anemia/Bleeding Disorder/ Blood Clots
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bowel Problems (specific type): _____
- ☐ COPD/Bronchitis
- ☐ Cancer (specific type): _____
- ☐ Chest Pain (Chronic)
- ☐ Claustrophobic
- ☐ Depression
- ☐ Diabetes
- ☐ Fractured/Broken Bone (specific type & side (R/L): _____
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hypothyroidism/Other Hormonal
- ☐ Immune System Problems (specific type): _____
- ☐ Infectious Disease (specific type): _____
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Mental Abuse
- ☐ Mood Disorder
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Other: _____
- ☐ Pacemaker
- ☐ Physical Abuse
- ☐ Schizophrenia
- ☐ Seizure Disorder
- ☐ Sexual Abuse
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stent Placement
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Ulcer
- ☐ Women: Currently Pregnant?

SURGERY HISTORY: (Mark all surgeries that apply to you and list the year they were performed.)

- ☐ None Apply
- ☐ Appendectomy Year: _____
- ☐ Cardiac Defibrillator Year: _____
- ☐ Eye Surgery Year: _____
- ☐ Gall Bladder Year: _____
- ☐ Heart Attack Year: _____
- ☐ Heart Surgery Year: _____
- ☐ Hernia Year: _____
- ☐ Hysterectomy Year: _____
- ☐ Pacemaker Year: _____
- ☐ Spinal Surgery Year: _____
- ☐ Tonsillectomy Year: _____
- ☐ Trauma/Injury Year: _____
- ☐ Other: _____ Year: _____
- ☐ Other: _____ Year: _____
- ☐ Other: _____ Year: _____

☐ Total Replacement Surgery - (Body Part(s), Specific Date(s), & Side (Right / Left)) _____

Past Anesthesia Reactions: _____

FAMILY HISTORY: (Mark only those that apply to your Mother/father. Check M for mother or F for father.)

☐ None Apply

- Alcohol Abuse (☐ M ☐ F)
- Alzheimer's Disease (☐ M ☐ F)
- Anemia/Bleeding Disorder/ Blood Clots (☐ M ☐ F)
- Anxiety (☐ M ☐ F)
- Apnea, Sleep (☐ M ☐ F)
- Arthritis (☐ M ☐ F)
- Asthma (☐ M ☐ F)
- Bipolar (☐ M ☐ F)
- Bowel Problems (specific type): _____ (☐ M ☐ F)
- COPD/Bronchitis (☐ M ☐ F)
- Cancer (specific type): _____ (☐ M ☐ F)
- Chest Pain (Chronic) (☐ M ☐ F)
- Depression (☐ M ☐ F)
- Diabetes (☐ M ☐ F)
- Gout (☐ M ☐ F)
- HIV/AIDS (☐ M ☐ F)
- Heart Disease (☐ M ☐ F)
- Hepatitis (☐ M ☐ F)
- High Cholesterol (☐ M ☐ F)
- Hypertension (☐ M ☐ F)
- Hypothyroidism/Other Hormonal (☐ M ☐ F)
- Immune System Problems (specific type): _____ (☐ M ☐ F)
- Infectious Disease (specific type): _____ (☐ M ☐ F)
- Jaundice (☐ M ☐ F)
- Kidney Disease (☐ M ☐ F)
- Mental Abuse (☐ M ☐ F)
- Mood Disorder (☐ M ☐ F)
- Osteoporosis (☐ M ☐ F)
- Other: _____ (☐ M ☐ F)
- Pacemaker (☐ M ☐ F)
- Physical Abuse (☐ M ☐ F)
- Schizophrenia (☐ M ☐ F)
- Seizure Disorder (☐ M ☐ F)
- Sexual Abuse (☐ M ☐ F)
- Shortness of Breath (☐ M ☐ F)
- Stent Placement (☐ M ☐ F)
- Stroke (☐ M ☐ F)
- Substance Abuse (☐ M ☐ F)
- Ulcer (☐ M ☐ F)

Please list any other information you think would be relevant to your visit with us today in the space provided below:

_____

Southern Indiana Physicians

Ambulatory Registration

PATIENT DEMOGRAPHIC INFORMATION

Legal Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

County of Residence _____ Country _____ SSN _____

Preferred Language of Communication: ☐ English ☐ Spanish ☐ Other _____

Gender: M F Marital Status _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Multiracial ☐ Unknown ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined ☐ Unknown

Phone _____ Alternate Phone _____ Email Address _____

Preferred Method of Communication: ☐ Email ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Declined

Primary Care Doctor _____ Referring Doctor _____

Employment Status (Circle One) Full-time Part-time Disabled Retired Not Employed Self Employed On Active Duty

Employer Name _____ Employer Phone _____

Retirement Date (if applicable) _____

Is visit due to accident? _____ If yes, Accident Type _____

Accident: Date _____ Time _____ Location _____

PATIENT GUARANTOR INFORMATION *(Complete if other than patient)*

Patient Relationship to Guarantor _____ Date of Birth _____ Gender: M F

Last Name _____ First Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Employment Status (Circle One) Full-time Part-time Disabled Retired Not Employed Self Employed On Active Duty

Employer Name _____ Employer Phone _____

Phone: _____ Alternate Phone _____ Email _____

NEXT OF KIN *(Emergency Contact Person Information)*

Patient Relationship to NOK _____ Date of Birth _____

Last Name _____ First Name _____ MI _____

Phone: _____ Alternate Phone _____ Email _____

Employer Name _____ Employer Phone _____

Alternate Contact Information Patient Relationship to Contact Person _____ Date of Birth _____

Last Name _____ First Name _____ MI _____

Phone: _____ Alternate Phone _____ Email _____

INSURANCE INFORMATION

Member Name _____ Date of Birth _____ Name of Insurance _____

SSN _____ Group # _____ Member ID: _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Employer Phone _____

Secondary Information

Member Name _____ Date of Birth _____ Name of Insurance _____

SSN _____ Group # _____ Member ID: _____

Address _____ City _____ State _____ Zip _____

Employer Name _____ Employer Phone _____

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Ambulatory Registration

Southern Indiana Physicians

PREFERRED COMMUNICATION LIST

Patient Sticker

IU Health Southern Indiana Physicians is committed to ensuring the privacy and security of patient health information. Reasonable steps will be taken to give you, as our patient, an opportunity to agree or object to the release of specific medical information.

PATIENT COMMUNICATION:

☐ I permit IU Health Southern Indiana Physicians to communicate the identified information below by leaving voice mail at the following numbers.

Preferred phone #1:_____ Secondary phone #2:_____

- ☐ Information about normal test results
- ☐ Information about prescriptions / prescription pick up

☐ I do **NOT** permit IU Health Southern Indiana Physicians to leave voice mail on my phones.

FAMILY & FRIENDS COMMUNICATION:

I permit IU Health Southern Indiana Physicians to communicate with family and friends, as identified below, the following information about my treatment and health care.

1. **Authorized Individual** _____ **Phone Number** _____ **Relationship** _____
   - ☐ Any and all information
   - ☐ Information necessary to schedule, confirm, cancel or reschedule appointments
   - ☐ Information about test results
   - ☐ Information about prescriptions / prescription pick-up
   - ☐ Information about my bills or account
2. **Authorized Individual** _____ **Phone Number** _____ **Relationship** _____
   - ☐ Any and all information
   - ☐ Information necessary to schedule, confirm, cancel or reschedule appointments
   - ☐ Information about test results
   - ☐ Information about prescriptions / prescription pick-up
   - ☐ Information about my bills or account
3. **Authorized Individual** _____ **Phone Number** _____ **Relationship** _____
   - ☐ Any and all information
   - ☐ Information necessary to schedule, confirm, cancel or reschedule appointments
   - ☐ Information about test results
   - ☐ Information about prescriptions / prescription pick-up
   - ☐ Information about my bills or account

I understand that this information may be subject to re-disclosure by my family and friends, and that the disclosed information is then beyond the privacy protections of the practice.

I understand this permission is valid until revoked by me. I understand that if I choose to revoke this authorization, I must do so in writing and provide to the office staff at this practice. I understand IU Health Southern Indiana Physicians will not release any information on voice mail or to family or friends regarding HIV, sexually transmitted diseases, pregnancy tests or contraceptive counseling. This information will be released only to the patient, and to any public health agency to which IU Health Southern Indiana Physicians is legally bound to report such information.

(Optional) I would like my code word to be _____.

Patient Name _____ **Date of Birth** _____

Patient/Guardian Signature _____ **Patient/Guardian Printed Name** _____ **Date** _____

Witness Signature _____ **Witness Printed Name** _____ **Date** _____