FAMILY HEALTH CENTER OF ARDMORE

1104 Walnut Drive
Ardmore, OK 73401
(phone) 580-226-0543 (fax) 580-226-2284

ALL SECTIONS MUST BE FILLED IN - NO BLANK AREAS

Michael Carnahan, MD Tom McCulloh, DO Miguel Camacho, MD Gina Hernandez, PA-C Sharon Hall, APRN-CNP Shawn Fadum, PA-C

PATIENT INFORMATION

Patient's First Name: MI: Last Name:

Birthdate: Age: Sex: F M Marital Status: S M D W

Address: City: St: Zip Code:

Home # ( ) Cell # ( ) Work # ( )

Email: SSN# / /

Primary Language: Race: African American Native American Caucasian Asian Hispanic

Pharmacy Name:_____ Emergency Contact:_____ _____ _____

GUARANTOR INFORMATION

Guarantor First Name: MI: Last Name: Birthdate:

Address: City: St: Zip Code: SSN#: / /

Home # ( ) Cell # ( ) Work # ( )

Guarantor Employer:

INSURANCE INFORMATION

PLEASE FURNISH A COPY OF INSURANCE CARDS AND DRIVERS LICENSE

Primary Insurance Company: Effective Date:

Claim Address: City/St: / Zip Code:

ID #: Group #:

Cardholder Name: Birthdate: SSN #:

Cardholder Address: City/St: / Zip Code:

Cardholder's Employer :

Secondary Insurance Company: Effective Date:

Claim Address: City/St: / Zip Code:

ID #: Group #:

Cardholder Name: Birthdate: SSN #:

Cardholder Address: City/St: / Zip Code:

Cardholder's Employer :

Tertiary Insurance Company: **Please write information on the back**

I hereby state that the above information is true to the best of my knowledge. I authorize Family Health Center to release my information; including my cellular phone number and/or email address to the insurance company, collection agency, employer, physicians, institutions, or third party payers, as required for claims filed and/or collection contract. In addition, I have reviewed the Notice of Privacy Practice and I may receive a printed copy upon verbal or written request. Furthermore, I authorize direct payment to be made to Family Health Center for any medical services rendered. I understand if any charges are not covered by my insurance, I am responsible for the fees.

Signature of Patient/Parent/Legal Guardian	Printed Name	Date

MEDICAL INFORMATION — PLEASE ANSWER ALL QUESTIONS

PATIENT NAME: _____

FAMILY PHYSICIAN: _____ PHONE: _____

WHO REFERRED YOU TO US? _____ PHONE: _____

SYMPTOMS *AND/OR* CHIEF COMPLAINT: _____

DATE SYMPTOMS FIRST APPEARED: _____

IS THIS A WORK RELATED INJURY? Y N IF YES, DATE OF INJURY? _____

CURRENT MEDICATIONS:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

WHAT PHARMACY DO YOU PRIMARILY USE? _____ PHONE: _____

MEDICATION ALLERGIES:

_____ _____

_____ _____

_____ _____

PAST MEDICAL HISTORY

HAVE YOU EVER HAD OR CURRENTLY HAVE :

AIDS(HIV)	Y	N
Asthma	Y	N
Blood in Stool	Y	N
Blood in Urine	Y	N
Cancer	Y	N
Chronic Anemia	Y	N
Congestive Heart Failure	Y	N
Diabetes	Y	N
Difficulty Breathing	Y	N
Heart Attack	Y	N
Heart Disease	Y	N
High Blood Pressure	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Lung Disease	Y	N
Skin Irritations	Y	N
Stroke	Y	N
Thyroid	Y	N

Other: _____

_____

SYSTEMS

DO YOU HAVE PROBLEMS WITH:

Arteries or Veins	Y	N
Colon	Y	N
Easy Bruising	Y	N
Excessive Bleeding	Y	N
Eyes, Ears, Nose or Throat	Y	N
Heart	Y	N
Kidneys or Bladder	Y	N
Liver or Gallbladder	Y	N
Lungs	Y	N
Seizures	Y	N
Stomach	Y	N

Other: _____

_____

VITALS: (TO BE FILLED OUT BY OFFICE STAFF ONLY)

BP _____ T _____ R _____ P _____

HT _____ WT *(ACTUAL)* _____

STATED WT *(UNABLE TO STAND)*: _____

PLEASE LIST ANY PREVIOUS SURGERIES:

PROCEDURE	DATE

SOCIAL HISTORY

DO YOU SMOKE? Y N IF YES, PACKS PER DAY: _____ HOW MANY YEARS? _____

DO YOU DRINK ALCOHOL? Y N IF YES, HOW MUCH PER DAY? _____

FAMILY HISTORY

ANY HISTORY OF CANCER, HEART DISEASE, DIABETES?

TYPE	RELATION TO YOU	TYPE	RELATION TO YOU

SURGICAL ASSOCIATES

731 12TH ST NW SUITE 100
Ardmore, OK 73401
580/223-3216 (f) 580/223-4184

Patient Questionaire of Symptoms

Patient Name: _____ Date: _____

Do you currently have problems with any of the following?

Reflux	❑ YES	❑ NO
Heartburn	❑ YES	❑ NO
Epigastric Pain	❑ YES	❑ NO
Abdominal Pain	❑ YES	❑ NO
Abdominal Bloating	❑ YES	❑ NO
Diarrhea	❑ YES	❑ NO
Constipation	❑ YES	❑ NO
Changes in Bowel Habits	❑ YES	❑ NO
Difficulty Swallowing	❑ YES	❑ NO
Excessive Gas	❑ YES	❑ NO
Rectal Bleeding	❑ YES	❑ NO
Black Stools	❑ YES	❑ NO
Hemorrhoids	❑ YES	❑ NO
History of Colon Polyps	❑ YES	❑ NO
Anemia	❑ YES	❑ NO
Nausea / Vomiting	❑ YES	❑ NO

Are you taking medication or have you ever taken medications for any of the above symptoms?_____

If yes, please list :

medication	Duration Taken	Results

Have you previously had an EGD? (Scope down the throat) If yes, when? _____

Have you previously had a Colonoscopy? _____ If yes, when? _____