Patients Name:

Welcome to EVANS MEDICAL GROUP

______________________/________/__________________________Marital Status:__________

First MI Last

Mailing Address:____Apt#:__________

If P.O. Box , **provide street address**:____

City:______________________State:__________ Zip Code:________________

Preferred contact phone #: Cell:(   )__________Home:(   )__________ Other:(   )__________

Patient (Guardian) **email** address:__________________________________

Do not submit the email address of a minor child.

Date of Birth:____/____/____ Age______ [ ]Male [ ]Female Social Security #:______—_____—______

If patient is under 18 years of age or ***is cared for*** *by a guardian or caregiver, who is financially responsible for payment to Evans Medical Group?*

____*Relationship to patient?*____________

_____Have you submitted the name and all requested information of the person that is financially responsible for the patient, all necessary insurance information and the "Named Insured" as well as all other required information?

This section for Minor Patients or Patients with Guardians

Mother / Father / Guardian's:

__________________________/__________/__________________________

First MI Last

Mailing Address:____Apt#__________

City:______________________State:__________ Zip:________________

Preferred contact phone #:Cell:(   )__________Home:(   )__________ Other:(   )__________

Social Security#:______-_____-______Relationship to patient__________DOB:_____/_____/_____ [ ]Male [ ]Female

Consent for treatment:

I am the _____*custodial parent* _____*legal guardian* having legal custody of the above-named patient.

I authorize the physician and staff at Evans Medical Group any acts that may be necessary or proper to provide for the health care of the stated patient child. Such authorization is in effect until revoked. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained. By signing below, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

Legal Custodian:_______________________________________**Date:**______________

turn over

Authorization for Treatment, Financial Obligation and Privacy Notice (HIPAA)

Name of Patient:

___________________________/_______/________________________________DOB_____/_____/_____
First MI Last

Consent for Treatment: I, the undersigned, a patient of Evans Medical Group, requests and authorize my attending physician and whomever he may designate as his/her associates or assistants, to administer such treatment as is medically necessary. I voluntarily consent to said medical care, evaluation and treatment, as well as any information release necessary to obtain such. This would include such services, care, diagnostic procedures, and/or medical treatments as the physician deems reasonable and necessary. These would include, but not be limited to, the performance of services involving pathology, radiology (bone density) and immunizations. In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I am aware that the practice of medicine and surgery is no exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

Financial Obligation for Evans Medical Group: I authorize payment of medical benefits to Evans Medical Group for services rendered. I understand and agree that I am financially responsible for the payment of all charges, that are my responsibility, for services provided, regardless of insurance coverage or other third party coverage unless waived by contractual agreements between Evans Medical Group and my insurer or if prohibited by state, federal laws or regulations. If the charges, that are my responsibility, are not paid within thirty (30) days of receipt of the bill, I agree to pay any additional expenses incurred due to the delinquent account, including collection agency cost, and/or reasonable attorney fees if applicable, if the account is placed for collection. If the charges, that are my responsibility, are not paid and no arrangements are made for payment to Evans Medical Group and it is necessary to send my account to collection, collection agency and/or attorney, I will be responsible for payment of all collection, collection agency costs and/or reasonable attorney fees. All returned checks incur a $35.00 service charge or the maximum allowed by law, to be paid by cash or credit card along with balance of patients account within 10 days of notification by Evans Medical Group, or its assigned agent.

Failure to comply and meet financial responsibility may also result in a patient discharge from practice.

Privacy Notice (HIPAA): by my signature below I acknowledge that the Health Insurance Portability and Accountability Act has been made available to me by Evans Medical Group and a copy provided, upon request, for me at my discretion. I hereby authorize Evans Medical Group to disclose information about myself (or another person for whom I have authority to sign) that is protected under federal law for the purposes of treatment, payment, and healthcare operations. I also authorize Evans Medical Group to communicate with the individuals named below about my condition or treatment, all other individuals will be excluded.

Name	Relationship	Preferred Phone #
		( )
		( )
		( )

The Patient Communication form has been provided for my review. It is my responsibility to notify the front desk if I wish to receive a copy of this form.

I acknowledge that it is my responsibility as a patient or parent/guardian of Evans Medical Group to notify the office in regards to any changes of the information provided verbally or contained within this patient information form to include insurance, mailing address, custody of minors and/or health information.

Signature required by patient, parent if minor child, guardian, or representative if Medicare, for acknowledgement of the above Consent of Treatment, Financial Obligation and Privacy Notice:

Signature:____Date:_____________

11/2007

If you have any questions or need assistance, please return to the front desk.

EVANS MEDICAL GROUP
Caring for the Whole Family www.evans.md

DATE:___________________

NAME____ DATE OF BIRTH ____________________

PAST MEDICAL HISTORY Have you been diagnosed with a medical condition? ***Circle all that apply:***
Diabetes, High Blood Pressure, High Cholesterol, Heart Rhythm Problems, Coronary Disease (such as Heart Attack or Angina), Congestive Heart Failure, Asthma, Emphysema or other Lung Problems, Seizures, Acid Reflux (GERD), Stomach Ulcers, Intestinal Problems, Kidney Problems, Anemia, Cancer- what kind___________, Depression, Anxiety, Arthritis, Major Back Problems, Osteoporosis.
Other____

Have you ever been hospitalized for any reason other than surgery ? ______No ______Yes
Date _____________ Reason for hospitalization ____
Date _____________ Reason for hospitalization ____
List any doctors you see regularly and their specialty: ____
____

Have you ever had surgery? ______No ______Yes ***Circle all that apply and give DATE/YEAR of surgery***
Tonsils _______ Gallbladder_______ Appendix_______ Hysterectomy_______ Hernia_______ (Other, please list)

Type of surgery	Date

FEMALE PATIENTS: How many times have you been pregnant? _______ Miscarried _______ Aborted _______
Have you had an abnormal Pap Smear in the past _______No ______Yes
If yes explain outcome ____

List all medications you currently take (including vitamins, remedies and non prescription medications).

Name	Strength	Directions (once a day, etc)

Are you allergic to any medication? ______No ______ Yes
Medication___________________________________ Reaction______________________________
___________________________________ ______________________________
___________________________________ ______________________________
___________________________________ ______________________________

SOCIAL HISTORY

Preferred Nickname ____
Marital status : ***Circle one*** Single Engaged Married Widowed Separated Divorced
Who lives in your home with you? (Children,Grandparents, other relatives)___________________________________
Do you have any children? ______No ______Yes Number of children ____________
Occupation: ____
Highest level of education completed ____
School attended: ____
Hobbies: ____
Inside pets: ______No ______Yes Type: ____
Religion: __________________________________ Church attended: ____
To what level is religion (and/or God) a source of strength and comfort to you? ***Circle one***
Not very much Somewhat Quite a bit A great deal
Have you ever been exposed to TB (tuberculosis) or worked in a prison or with homeless people? ______No ______Yes

Have you ever traveled overseas? ______No ______Yes To which country/countries? ______________________________

Do you smoke? ______No ______Yes Packs per day ______________ Year started _________________
Have you smoked in the past? ______No ______Yes Year started ______________ Year stopped _______________
Do you use any smokeless tobacco products (chewing tobacco or dip)? ______No ______Yes

Do you drink alcohol? ______No ______Yes Amount per day: ***Circle one*** <1 1, 2, 3, 4+
Type: ***Circle all that apply*** Beer Wine Mixed drink Hard liquor
Have you ever used illegal drugs? ______None ______Past ______Recent past ______Present
Type of drug: ____
Are you sexually active outside of marriage? ______No ______Yes
Do you have any risk factors for HIV, such as IV drug use, multiple sex partners, or past of present gay lifestyle?
______No ______Yes
Have you ever received a blood transfusion? ______No ______Yes

FAMILY HISTORY (Specifically; Father, Mother, Sister, Brother)

Condition/Disease	Circle one		Relative/ Relatives
Diabetes	Yes	No	
Heart Attack/Heart Disease	Yes	No	
Stroke	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
Drug/Alcohol Problem	Yes	No	
Psychiatric Problem	Yes	No	
Colon Cancer/Polyps	Yes	No	
Breast Cancer (including grandmothers)	Yes	No	
Prostate Cancer (including grandfathers)	Yes	No	
Osteoporosis (including grandparents)	Yes	No	

Other family history that you may think your physician may consider important information concerning your health.
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