

Date: _____ (Please Print) Home Phone: (____) _____

Patient Information

Date of Birth: ____ / ____ / ____

Name: _____ Social Security #: _____
Last name First Name Middle Initial

Mailing Address: _____ Cell Phone: (____) _____

City: _____ State: _____ Zip: _____

Sex: M F Relationship Status: Married Widowed Single Minor
 Separated Divorced Partnered for ____ years

Patient Employer/School: _____ Occupation: _____

In case of emergency, who should be notified? _____

Relationship: _____ Contact number: (____) _____

Insurance

Do you have Insurance? Yes No If No, stop here. Sign at bottom.

Have you supplied us with your insurance card? Yes No

If you do not have your card but know your insurance information, you can add it here:

Policy Holder's Name: _____

Insurance name: _____ Policy #: _____

Group #: _____ Date active: _____

Do you have a secondary insurance? Yes No If No, stop here. Sign at bottom.

Have you supplied us with your insurance card? Yes No

If you do not have your card but know your insurance information, you can add it here:

Policy Holder's Name: _____

Insurance name: _____ Policy #: _____

Group #: _____ Date active: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with above-named insurance company(ies) and assign directly to Dr. Krishnamurthi and Clinico Llc all insurance benefits, if any, 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 the above-named 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 one year from the date signed below.

Signature of patient, Parent, Guardian or Personal Representative

Date

Print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

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

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- Arms Hips
- Back Legs
- Feet Neck
- Hands Shoulders

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

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

CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision - Flashes
- Vision - Halos

SKIN

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore that won't heal

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 _____

Conditions

Check (✓) conditions 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 Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

Medications

List medications you are currently taking.

Allergies

Pharmacy Name _____ Phone _____

Health History

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) 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, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

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

Serious Illness/Injuries	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.

 Signature of Patient, Parent, Guardian or Personal Representative

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

 Reviewed By

Pregnancies

Year of Birth	Sex of Birth	Complications if any

Health Habits

Check (✓) which you use and how much you use.

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Occupational

Check (✓) if your work exposes you to:

	Stress		Hazardous Substances
	Heavy Lifting		Other

 Occupation

 Date

 Relationship to Patient

 Date

Privacy Practices Acknowledgement

Clinico, L.L.C. Rural Health Care Clinic

103 E Main, Beggs, Oklahoma, 74421

918 - 267 - 7000

Kerri Ellis, ARNP <> Lindsey Groves, ARNP <> Subramaniam Krishnamurthi, MD

Acknowledgement Form

I have been provided an opportunity to review a copy of the Notice of Privacy Practices and have been offered information regarding Advance Directives, DNR, Living Will, and Durable power of Attorney for health care.

Have you executed an Advance Directive? YES NO

Name: _____ Birthday: _____

Signature: _____

Date: _____

Access To Records

The following person(s) may be given information about my history and treatment:
