# NEW PATIENT INFORMATION

SPARKS & FAVOR, P.C.

| | | | |
|---|---|---|---|
| Name | | | Social Security Number |
| Address | City | State | Zip |
| Home Phone Number | Cell Phone Number | Work Phone Number | |
| Birth date | Marital Status S ☐ M ☐ D ☐ W ☐ | Email Address | |
| Place of Employment | | Occupation | |
| Spouse/Partner's Name | Birth date | Occupation | |
| Place of Employment | Primary Phone Number Home ☐ Cell ☐ | Work Phone | |
| Referring Doctor/Primary Physician | | | |

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| Insurance Company | | Contract/Policy Number | |
| Name of Employer | | Group Number | |
| Name of Policy Holder | Date of Birth | Relationship | |
| Address | City | State | Zip |
| Insurance Company | | Contract/Policy Number | |
| Name of Employer | | Group Number | |
| Name of Policy Holder | Date of Birth | Relationship | |
| Address | City | State | Zip |

## In Case of Emergency Please Notify:

| | | | |
|---|---|---|---|
| Name | | Relationship | |
| Address | City | State | Zip |
| Primary Phone Number Home ☐ Cell ☐ | Work Phone Number | | |

## MEDICARE ASSIGNMENT

Statement to permit payment of medical benefits to physicians.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign benefits payable for physicians service or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient or Responsible Party _____ Date_____

## ALL OTHER INSURANCE

I hereby authorize Sparks & Favor, PC to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges. I hereby assign and authorize payment directly to Sparks & Favor, PC of all benefits payable under the terms of any insurance policy listed above. I realize the insurance, and/or liability claims may not pay all of the bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including Attorney's fee and waive my exemption under the constitution and laws of the State of Alabama.

Patient or Responsible Party _____ Date_____

# NEW PATIENT INFORMATION

SPARKS & FAVOR, P.C.

PATIENT NAME_____

**Why are you here to see the doctor today?**

- ☐ Annual
- ☐ Problem(s): 1)_____
  2)_____

Date of last Pap Smear:_____ ☐ Normal ☐ Abnormal ☐ N/A

Date of last Mammogram:_____ ☐ Normal ☐ Abnormal ☐ N/A

Date of last Colonoscopy:_____ ☐ Normal ☐ Abnormal ☐ N/A

Current Medications:_____

_____

Allergies:_____

**Illness(es):**

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Thyroid Dysfunction
- ☐ Asthma
- ☐ Cancer
- ☐ Thrombosis or Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ Other Illness: _____

**Surgeries (Procedure/Date):**

1._____
2._____
3._____
4._____
5._____
6._____

**Tobacco Use:** ☐ No ☐ Yes _____Packs per day

**Alcohol Use:** ☐ No ☐ Yes _____Drinks per day

**Family History:**

Mother ☐ Living ☐ Deceased - Cause:_____

Father ☐ Living ☐ Deceased - Cause:_____

Sibling: _____ Number Living _____ Number Deceased - Cause:_____

- ☐ Diabetes_____
- ☐ Heart Disease _____
- ☐ High Blood Pressure_____
- ☐ Osteoporosis_____
- ☐ Colon Cancer_____
- ☐ Breast Cancer_____
- ☐ Ovarian Cancer_____
- ☐ Other Cancer_____

**Obstetrical History:**

| Total Pregnancies | Full Term Pregnancies | Premature Pregnancies | Abortions | Miscarriages | Tubal Pregnancies | Twins (sets) | # of Living Children |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**Pregnancy Details** *(complete if you are pregnant or planning future pregnancies):*

| Date | Gestational Age (wks) | Labor Hours | Weight | Sex | Type Delivery | Anesthesia | Place of Delivery | Complications/Comments/Name |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

# NEW PATIENT INFORMATION

SPARKS & FAVOR, P.C.

**Menstrual History:**

Date Last Period Started:_____ How many days do you bleed each cycle?_____

Are you having any problems with your menstrual cycle? ☐ No ☐ Yes

Describe your menses: ☐ Regular ☐ Irregular ☐ Heavy ☐ Painful ☐ Clots

How long is your menstrual cycle? _____ days (1st day of one period to 1st day of next period)

**Contraception** (at the present time): ☐ None ☐ Hysterectomy ☐ Tubal Ligation ☐ Vasectomy
☐ Birth Control Pill ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Rhythm

**Have you noticed recent problems related to the following:**

General Health? ☐ No problems ☐ Yes – ☐ Wt. Gain ☐ Wt. Loss ☐ Fever ☐ Fatigue
☐ Other:_____

Eyes? ☐ No problems ☐ Yes – ☐ Vision Change ☐ Glaucoma
☐ Other:_____

Ear/Nose/Throat? ☐ No problems ☐ Yes – ☐ Ulcers ☐ Sinusitis ☐ Ringing in Ears
☐ Other:_____

Heart? ☐ No problems ☐ Yes – ☐ Chest Pain ☐ Shortness of Breath ☐ Irregular Heart Beat
☐ Other:_____

Lungs? ☐ No problems ☐ Yes – ☐ Wheezing ☐ Cough ☐ Coughing Up Blood
☐ Other:_____

Stomach/Colon? ☐ No problems ☑ Yes – ☐ Diarrhea ☐ Blood in Stool ☐ Nausea ☐ Constipation
☐ Other:_____

Kidney/Bladder? ☐ No problems ☐ Yes – ☐ Blood in Urine ☐ Dysuria ☐ Urgency ☐ Frequency ☐ Incontinence
☐ Other:_____

Muscles/Bones/Joints? ☐ No problems ☐ Yes – ☐ Muscle Weakness ☐ Joint Pain ☐ Muscle Pain
☐ Other:_____

Nervous System? ☐ No problems ☐ Yes – ☐ Fainting Spells ☐ Seizures ☐ Numbness ☐ Memory Loss
☐ Other:_____

State of Mind? ☐ No problems ☐ Yes – ☐ Depression ☐ Crying ☐ Anxiety
☐ Other:_____

Endocrine System? ☐ No problems ☐ Yes – ☐ Diabetes ☐ Thyroid Disorder ☐ Heat/Cold Intolerance
☐ Other:_____

Blood & Lymph Nodes? ☐ No problems ☐ Yes – ☐ Easy Bruising ☐ Free Bleeder ☐ Enlarged Lymph Nodes ☐ Transfusions
☐ Other:_____

Skin? ☐ No problems ☐ Yes – ☐ Rash ☐ Ulcers ☐ Moles (Enlarging/Changing)
☐ Other:_____

Breasts? ☐ No problems ☐ Yes – ☐ Pain in Breast ☐ Nipple Discharge ☐ Breast Nodule
☐ Other:_____

Patient Signature_____ Date_____

**PLEASE COMPLETE IF YOU ARE PREGNANT OR PLANNING A PREGNANCY.**

Please help us evaluate potential genetic risks for you pregnancy by answering the follwoing questions. Please check the 'Yes' or 'No' answer. Please provide the details of any positive in the space at the bottom of this page.

Have you, the baby's father or anyone in either family ever had:

| | | |
|---|---|---|
| Down's Syndrome | ☐ Yes | ☐ No |
| Other Chromosome Abnormality | ☐ Yes | ☐ No |
| Neural Tube Defect, such as Open Spine | ☐ Yes | ☐ No |
| Any Other "Birth Defects" | ☐ Yes | ☐ No |
| Cystic Fibrosis | ☐ Yes | ☐ No |
| Muscular Dystrophy | ☐ Yes | ☐ No |
| Sickle Cell Disease | ☐ Yes | ☐ No |
| Hemophilia | ☐ Yes | ☐ No |
| Mental Retardation | ☐ Yes | ☐ No |
| Tay Sachs Disease | ☐ Yes | ☐ No |
| Multiple Miscarriages | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No |
| Thallasemia (Inherited Anemia) | ☐ Yes | ☐ No |

| **If you or your spouse is:** | **Have you been tested for:** | | | **Results:** |
|---|---|---|---|---|
| _____ Black | Sickle Cell | ☐ Yes | ☐ No | _____ |
| _____ Italian, Greek | B-Thallasemia | ☐ Yes | ☐ No | _____ |
| _____ Mediterranean | Tay Sachs | ☐ Yes | ☐ No | _____ |
| _____ Southeast Asian | | | | |
| _____ Jewish | | | | |

Besides vitamins, have you taken any medication since your last period? _____

If yes, please list medication: _____

| | | |
|---|---|---|
| Have you ever used "recreational" drugs? | ☐ Yes | ☐ No |
| Have you ever had herpes, gonorrhea, or syphilis? | ☐ Yes | ☐ No |
| Chlamydia, genital warts, or any sexually transmitted disease? | ☐ Yes | ☐ No |

Details: _____

_____

_____

_____ ____/____/____ _____

Your Name (Please Print) Date Your Signature

# *Sparks & Favor, P.C.*

## PATIENT CONTACT INFORMATION SHEET

**Patient Name:** _____

**Social Security Number:** _____

**Any physician, staff, employee or representative of Sparks & Favor, P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:**

☐ **Check here if you choose not to allow access of your medical records to anyone.**

| Name | Relationship | Phone Number(s) |
|---|---|---|
| Name | Relationship | Phone Number(s) |
| Name | Relationship | Phone Number(s) |
| Name | Relationship | Phone Number(s) |
| Name | Relationship | Phone Number(s) |

**I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to re-disclosure by the individual(s).**

**Patient Signature:** _____ **Date:** _____