Trinity Medical WNY, PC

# Patient Demographic Information

Date of Appointment: _____ Patient Legal Name: _____ Nickname: _____

Date of Birth: _____ Age: _____ Ht.: _____ Wt.: _____ SSN: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Race: _____ Primary Language: _____ Ethnicity: ☐ Not Hispanic/Latino ☐ Hispanic/Latino ☐ Declined

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Lives with: ☐ Alone ☐ Spouse ☐ Other (specify): _____

Are you currently working: ☐ Yes ☐ No Full time: ☐ Yes ☐ No Occupation: _____

If not employed, why: ☐ Retired ☐ Disabled, date: _____ ☐ Other (specify): _____ Length of Employment: _____

Employer: _____ Address: _____ Phone: _____

Parent/Guarantor Name: _____ SSN: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Address: _____ Phone: _____

Referring Physician: _____ Address: _____ Phone: _____

Primary Care Physician: _____ Address: _____ Phone: _____

Date of last visit with Primary Care Physician: _____

Pharmacy Name: _____ Address: _____ Phone: _____

Primary Health Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Employer: _____

Secondary Health Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Name: _____ Date of Birth: _____ Employer: _____

Is there another insurance primary to Medicare: ☐ No ☐ Yes If yes, reason: _____

Do you have active Medicaid insurance: ☐ Yes ☐ No Is today's visit related to an automobile or wok injury: ☐ Yes ☐ No

**Complete only if related to automobile or work injury:** ☐ Work Injury ☐ Automobile Accident Date of Accident: _____

Insurance Carrier Name: _____ Address: _____ Phone: _____

Carrier Claim Number: _____ Adjuster's Name: _____ Ext. (if applicable): _____

If visit is related to a work injury or automobile accident please complete the No Fault/Worker's Compensation Questionnaire and also the Worker's Compensation A-9 form or the No Faults Assignment of Benefits form.



Physician signature _____ Date: _____

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# Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Latex ☐ Pollen ☐ Iodine ☐ Nickel ☐ Cobalt ☐ Chromate
Other (specify): _____ Reaction: _____

Medications: Please list all current medications, including over the counter medications, such as vitamins. Attach additional sheets if necessary.

| Drug | Strength | Dose (how often) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Surgeries: Please list all prior inpatient or outpatient procedures. Attach additional sheets if necessary. ☐ None

Anesthesia complications: ☐ No ☐ Yes Explain: _____

| Surgery | Date | Surgery | Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently using any assistive devices for ambulation? ☐ No ☐ Yes Explain: _____



Physician signature _____ Date: _____

Trinity Medical WNY, PC

# Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Please check conditions you currently have, or have had in the past:

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Eating Disorder: _____ | ☐ Miscarriage | ☐ Respiratory Disease |
| ☐ Anemia | ☐ Gout | ☐ Mononucleosis | ☐ Rheumatoid Arthritis |
| ☐ Arthritis | ☐ Hepatitis A, B, or C (circle one) | ☐ Multiple Sclerosis | ☐ Sleep Apnea |
| ☐ Asthma | ☐ Hernia | ☐ Mumps | ☐ Scarlett Fever |
| ☐ Bleeding Disorder | ☐ HIV Positive | ☐ Osteoporosis | ☐ Thyroid Disease |
| ☐ Cancer: _____ | ☐ Kidney Disease | ☐ Pacemaker/Defibrillator | ☐ Tuberculosis |
| ☐ Cardiovascular Disease | ☐ Liver Disease | ☐ Psychiatric Condition | ☐ Typhoid Fever |
| ☐ Chemical Dependency | ☐ Measles | ☐ Pneumonia | ☐ Ulcers |
| ☐ Chicken Pox | ☐ Migraine headache | ☐ Polio | ☐ Venereal Disease |
| ☐ Diabetes (Insulin Dependent) | ☐ Other (please specify) _____ | | |
| ☐ Diabetes (Non-Insulin Dependent) | _____ | | |

Please check any symptoms you are currently experiencing:

| Constitutional | Cardiovascular | Gastrointestinal | Skin | Neurologic |
|---|---|---|---|---|
| ☐ Chills | ☐ Blood clots | ☐ Abdominal pain | ☐ Bruising | ☐ Confusion |
| ☐ Fainting | ☐ Edema | ☐ Change in appetite | ☐ Lesions | ☐ Depression |
| ☐ Impaired growth | ☐ Coldness in extremities | ☐ Constipation | ☐ Ulcers | ☐ Vertigo |
| ☐ Change in height | ☐ Faintness/dizziness | ☐ Diarrhea | ☐ Warts | ☐ Numbness |
| ☐ Change in weight | ☐ Chest pain | ☐ Excessive vomiting | ☐ Brittle nails | ☐ Tingling |
| ☐ Shakiness | ☐ Other: _____ | ☐ Other: _____ | ☐ Thickened nails | ☐ Other: _____ |
| ☐ Other: _____ | | | ☐ Other: _____ | |

| Musculoskeletal | | | | |
|---|---|---|---|---|
| ☐ Fibromyalgia | ☐ Difficulty ambulating | ☐ Instability | ☐ Muscle cramps | ☐ Muscle weakness |
| ☐ Joint pain | ☐ Muscle stiffness | ☐ Leg swelling | ☐ Movement limitations | ☐ Tremors |

☐ Other: _____

Personal Habits:

Do you currently smoke: ☐ No ☐ Yes Former smoker: ☐ No ☐ Yes Type and amount: _____

Do you currently use alcohol: ☐ No ☐ Yes Type and amount: _____

Do you currently use drugs: ☐ No ☐ Yes Type and amount: _____

Do you currently follow any special diet: ☐ No ☐ Yes Explain: _____

Do you currently exercise: ☐ No ☐ Yes Type and frequency: _____

List highest grade completed or degree received: _____



Physician signature _____ Date: _____

Trinity Medical WNY, PC

# Patient Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History: List all major medical illness for each member.

Mother: _____

Father: _____

Grandparents: _____

Siblings: _____

Children: _____

The information on this form is accurate to the best of my knowledge. I understand it is my responsibility to notify the office of any changes in the information contained on this form. I hereby give my consent to Trinity Medical, WNY to use and disclose protected health information about me to carry out treatment, payment, and health care operations. I authorize payment of medical benefits to the named physician/practice for services rendered. I understand that I am responsible for any additional fees incurred as a result of placing my account with an outside collection agency.

x _____ Date: _____

Signature of Patient or Parent/Legal Guardian (if patient under 18 years of age)

x _____

Printed Name of person signing form if different from patient



Physician signature _____ Date: _____