PRIMARY MEDICINE
ASSOCIATES

Preferred Provider (if any): _____

NAME:_____DOB:_____

SSN:_____ BIRTH SEX: Male / Female

ADDRESS:_____

CITY_____STATE:_____ZIP:_____

PHONE:_____(alternate):_____

E-MAIL:_____

EMERGENCY CONTACT (name/relationship/phone number):_____

_____

LAST PRIMARY PHYSICIAN:_____LAST SEEN:_____

INSURANCE COMPANY:_____GROUP #:_____

CONTRACT NUMBER:_____CO-PAY AMOUNT:_____

ANY CONCERNS YOU MAY HAVE AT THIS TIME:_____

_____

PMA PHYSICIANS DO NOT WRITE PRESCRIPTIONS FOR PAIN MEDICATION AND OTHER CONTROLLED SUBSTANCES.

IF YOU HAVE MEDICAID INSURANCE, YOU WILL BE DIRECTED TO THE HEALTH DEPT. FOR YOUR IMMUNIZATIONS AND BLUE CARDS.

PMA Phone: (334)821-2708, Fax: (334)821-3309 pma@eamc.org

Patient's Name:_____ date of birth:_____

Please list **ALL MEDICATIONS** you are currently taking

(Prescription and over the counter) If none, please specify.

Medications	Dosage	Frequency

Please List **ALL** Allergies

If none, please specify

Allergies	Type of Reaction

Patient's Signature (Electronic):_____ Date:_____

Patient's Name:_____ date of birth:_____

Complete Medical History Form

Past medical history

A. Current Medical Diagnosis (Hypertension, Diabetes, etc.):_____

_____

Surgeries/Procedures dates:

T&A (tonsils):_____ Appendectomy date:_____ Gallbladder:_____

Hysterectomy:_____ Ovaries removed: Yes No (circle) Vasectomy_____

Other surgeries:_____

Colonoscopy:_____ mammogram:_____ PAP_____

B. Injuries/Fractures: (type, date, and how injured):_____

_____

_____

Family history

Mother: Age (if living)____ Age (at death)_____ Cause of death:_____

List any medical problems she has had:_____

_____

Father: Age (if living)____ Age (at death)_____ Cause of death:_____

List any medical problems he has had:_____

_____

Brother(s) ages and any medical problems he/they have had:_____

_____

Sister(s) ages and any medical problems she/they have had:_____

_____

Any other blood relatives with: (mother=M, father=F, brother=B, sister=S, mother's mother= M/M, mother's father=M/F, father's mother=F/M, father's father=F/F, aunt=A, uncle =U)

Diabetes:_____ High Blood Pressure:_____

Heart Attack:_____ High cholesterol:_____

Stroke:_____ Tuberculosis:_____

Alzheimer's:_____

Cancer (please list):_____

Patient's Signature (Electronic): _____Date:_____

Lifestyle History

A. Alcohol Intake:

What do you usually drink?_____ how much?_____ how often?_____

_____Do not drink alcohol

B. Tobacco: _____ vape _____ current smoker _____ex-smoker _____never

Current-Number of packs, pipes, cigars, dips per day?_____

When did you start smoking?_____ If ex-smoker, when did you quit?_____

C. Drugs/Substance Abuse: Type:_____ Frequency:_____

Still using: _____yes _____no

D. Work/Education:

Current occupation or school(year/major):_____

Any work related injuries?_____

E. Marital status: _____single _____married _____divorced _____ widowed

F. Have you ever been pregnant or do you have any children? ____yes ____no ____N/A

If yes, how many pregnancies/births/children?_____

G. Diet: Any special Diet? _____ number of meals per day? _____

Number of times per week you eat "fast food"?_____

H. Exercise: Do you exercise regularly?_____

What Activity?_____

How often and for how long?_____

I. Are you current on vaccinations (childhood, yearly, etc) _____ yes _____ no

Review of Systems

List any other problems, symptoms of concern to you:

Patient's Signature (Electronic):_____ Date:_____

PRIMARY MEDICINE
ASSOCIATES

Phone: 334-821-2708 * Fax: 334-821-3309 * pma@eamc.org
Dr. B. Wood * Dr. M. Canfield * Dr. R.Horak * Dr. A. Jones * Dr. D. Barlow * P. Marvets, CRNP

AUTHORIZATION TO DISCLOSE / RELEASE OR OBTAIN MEDICAL RECORDS. All disclosures are in compliance with federal and state laws, including the Health Insurance Portability and Accountability Act of 1195 (HIPAA), governing the use and disclosure of Protected Health Information (PHI)

I hereby authorize Primary Medicine Associates to _____ Disclose/ Release to _____ Obtain From

_____ _____ _____
Name of Person or Organization Telephone Fax

_____ _____ _____ _____
Address City State Zip

INFORMATION REQUESTED: I hereby agree to this authorization and understand that it must contain personally Identifiable Information and PHI as defined by HIPAA to ensure accuracy. I understand I have the right to limit the type of information released and to revoke this authorization by submitting a notice, in writing the the Privacy Officer. Unless revoked, this authorization will expire three months for date of signature or on the following date: _____. If I choose to limit the information released, I understand Primary Medicine Associates (PMA) may inform the requestor that portions of the record have been withheld. I understand the information disclosed may be subject to re-disclosure by the recipient and no longer be protected by PMA. PMA and its staff are hereby released from any legal responsibility or liability for disclosure of the below information to the extent indicated and authorized.

_____ PARTIAL medical records; please specify parts and dates to be released: _____

____Progress Notes ____ Immunizations ____ Xray Reports ____ Allergy ____Lab Report ____ Physical

____ GYN Report _____ Other: _____

_____ ALL medical records without exception; including all lab testing (HIV) and mental health treatment.

For the purpose of: _____

I authorize the release of my medical records as indicated above.

_____
Signature of patient or legal guardian Date

_____
Printed Name Date of Birth

_____
Address City, State Zip

_____
Telephone Number Social Security Number

_____
Witness Date

Note to recipient: This information has been disclosed to you from records whose confidentiality is protected by Federal and State Laws (including HIPPA) and prohibits you from further disclosure without written consent of the person to whom it pertains. Charges may apply for copies of medical records.

_____ Faxed _____ Copies Left for pt _____ Mailed Date _____