Patient Information

Last Name: ___________________ First Name:___________________ Middle Initial: ____ Date of Birth ____/____/____

Marital Status: Married____ Single____ Divorced____ Widowed____ Separated____ Sex: Male____ Female____

Address: ______________________________________ Apt #______ City___________________ State _____ Zip ________

Social Security Number _____-___-_____ **Best contact No**. __________________cell / home / work

Alternate No. _______________________ E-mail____

***How would you like to be contacted for appointment reminders? (must mark at least one method)**
Text ____ Voicemail ____ E-mail ____

We can TEXT patients some information regarding LAB Results, Prescriptions, Medications, Referrals and other general medical information. Would you like to be notified this way?

NO ____ YES ____ if yes, to what number (_______) ________________ - ________________.

Insurance Information:

Insurance Co. _______________________ Policy/ID No. _____________________ Group No. _______________________

Do you have Secondary Insurance: _______ No _______ Yes (Please hand card to the person helping you)

Emergency Contact Information

Name: ______________________________________ Phone No _______________________________

Pharmacy Information

Pharmacy Name: ___________________________________ Phone No.________________________________

Address: ____ City______________________ State_ ____ Zip ____________

Mail Order Pharmacy: ____________________________________ Phone No. _________________________________

Disclosure Information

Is there someone we have permission to contact or share medical information with on the patient's behalf?
Yes____ No____ (if yes, please list name(s)

________________________________ ________________________________ ________________________________

PF-200 Acknowledgement of Receipt of Notice of Privacy Practices
Our practice reserves the right to modify the privacy practices outlined in the notice.
I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed by E.S.Romanelli,MD,PA. I understand I am entitled to receive a copy of your Notice of Privacy Practices.

________________________________ ________________________________ __________________________
Name of Patient (Print) Signature Date

________________________________ ________________________________
Signature of Patient Representative Relationship to Patient

Medical History

Last Name: __________________ First Name: __________________ D.O.B: ______/______/______

Check all that apply:

Drug Allergies: ____________________ **Reaction**: ____________________
____________________ ____________________
____________________ ____________________

Non-Drug Allergies: Eggs_____ Tape_____ IPV Dye _____ Seafood_____ Other_______________

Childhood Illnesses: None significant _____ ADD _____ Asthma _____ Eczema _____
Nasal allergies _____ Other___________________________________

Adult Illnesses	Diagnosis date	
Arthritis	_______/_______/_______	Hospitalizations (Year : Illness)
Asthma	_______/_______/_______	___________________________________
Bipolar Disorder	_______/_______/_______	___________________________________
Cancer Of: ___________	_______/_______/_______	___________________________________
Stroke	_______/_______/_______	Surgeries
Depression	_______/_______/_______	___________________________________
Diabetes	_______/_______/_______	___________________________________
High Cholesterol	_______/_______/_______	___________________________________
GERD/Heartburn	_______/_______/_______	
Gestational Diabetes	_______/_______/_______	Prescribed Medications
Glaucoma	_______/_______/_______	___________________________________
Headaches	_______/_______/_______	___________________________________
Heart Attack	_______/_______/_______	___________________________________
CHF/Heart Failure	_______/_______/_______	
High Blood Pressure	_______/_______/_______	Non Prescription Medications
Thyroid Disease	_______/_______/_______	___________________________________
Pneumonia	_______/_______/_______	___________________________________
Osteoporosis	_______/_______/_______	___________________________________
Other: ______________	_______/_______/_______	

Health Maintenance/Prevention

When was the last time the following tests were performed?

Cholesterol	______/______/______	Flu Vaccine	______/______/______
Prostate/Rectal Exam	______/______/______	Tetanus	______/______/______
PSA	______/______/______	Hepatitis B(3 shots)	______/______/______
Mammogram	______/______/______	TB test/PPD	______/______/______
Dexa Scan/Osteoporosis	______/______/______		
Pap Smear	______/______/______	**What Colon test was done?**	
Pneumonia(Pneumovax)	______/______/______	Flex sigmoidoscopy	When: ____/____/____
Colon Screening	______/______/______	Colonoscopy	When: ____/____/____
		Stool Cards	When:____/____/____

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Social History
Marital Status ___________________
Occupation _____________________
Alcohol Consumption
None / Never a heavy drinker ______
Past heavy drinker but quit ______
Drink Socially ______
How many drinks (or beers) per day? ______
How many days per week do you drink? ______
Tobacco Consumption
None / Never ______
I currently smoke ______
How many packs per day? ______
How many packs per week? ______
I live with a smoker ______
I quit smoking ______ # of years ago
If you quit smoking, how many packs per day did you smoke and for how many years?
______ per day for ______ years.

Substance Abuse / Illegal drug use
None / Never ______
Illegal Drugs used in the past / recovered
Patient admits to:
Marijuana ______
Cocaine ______
Intravenous drug use ______
Narcotics ______
Amphetamines ______
Anabolic Steroids ______
Frequency?
Frequently ______
Infrequently ______
Rarely ______
Exercise
Yes ______ No ______
Frequency?
Frequently ______
Infrequently ______
Rarely ______

Family History

Mother's History
Healthy ______
Deceased due to ____________________
Significant for:
Diabetes ______
She developed it at the age of______
High blood pressure ______
Cancer of the ____________________
She developed it at the age of______
Stroke ______
Depression ______
Bipolar Disorder ______
Glaucoma ______
Cholesterol abnormality ______
Osteoporosis ______
Thyroid disease ______
Heart disease ______

Father's History
Healthy ______
Deceased due to ____________________
Significant for:
Diabetes ______
He developed it at the age of______
High blood pressure ______
Cancer of the ____________________
He developed it at the age of______
Stroke ______
Depression ______
Bipolar Disorder ______
Glaucoma ______
Cholesterol abnormality ______
Osteoporosis ______
Thyroid disease ______
Heart disease ______

Other relatives with significant disease

Relationship: ________________________________
____
____
____

Disease: ____
____
____
____