LifeSpring
Health Systems

Date: ____________________

NEW PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS

CITY, STATE	ZIP	HOME PHONE	CELL PHONE

PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_______________

GENDER IDENTITY
❑ Male ❑ Female ❑ Transgender ❑Gender Queer ❑Other ❑Choose Not to Answer

SEXUAL ORIENTATION
❑Straight or Heterosexual ❑Lesbian, gay or homosexual ❑Bisexual ❑Something else ❑Don't know ❑Choose not to answer

PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)

HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE

GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)	ADDRESS

CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE

DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:

Release the following information:
❑ All Records ❑ Chart Notes ❑ Radiology Reports ❑ Operative Reports ❑ History & Physicals

RELEASE OF INFORMATION

I understand that:

- Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):

Date: ______________________

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

***** Preferred Pharmacy:**

Allergies				
❑ NONE/No Known Allergies	❑ Adhesive Tape	❑ Anesthesia	❑ Aspirin	❑ Codeine
❑ Dairy Products	❑ Iodine/Shellfish/Contrast Dye	❑ Latex	❑ Morphine	❑ Penicillin
❑ Sulfa Drugs	❑ Wheat	❑ Seasonal	❑ Environmental	
OTHER:				

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	**FATHER**	**SIBLING (Brother/Sister)**
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			
Kidney Disease			
Immune Disorder			
Other:			

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: ______________________________ ☐ Retired ☐ Disabled (reason ________________________)

☐**Yes** ☐**No -** Do you drink alcohol? ☐ Daily ☐Weekly ☐Infrequently ☐ Recovering Alcoholic

☐**Yes** ☐**No -** Do you use tobacco? ☐ Smoke (___ packs per day) ☐ Chew

☐**Yes** ☐**No -** Do you use drugs?

First Date of Last Menstrual Period:

Surgical/Hospitalization History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY/Hospitalization	**YEAR or DATE**	**DOCTOR**	**LOCATION**

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	**DOSAGE**	**PRESCRIBING DOCTOR**

Please list any other doctors or medical professionals you see:

NAME	**SPECIALITY/REASON**	**ADDRESS/LOCATION**

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)

Y	N	**GENERAL**
☐	☐	tired or fatigue
☐	☐	not feeling hungry
☐	☐	gained more than 10 lbs.
☐	☐	lost more than 10 lbs.
☐	☐	trouble sleeping
☐	☐	excessive snoring
☐	☐	fever/chills/night sweats
☐	☐	more thirsty lately
☐	☐	unexplained lump

Y	N	**HEAD AND NECK**
☐	☐	frequent headaches
☐	☐	neck pains
☐	☐	neck lumps
☐	☐	enlarged thyroid

Y	N	**EYES**
☐	☐	wears glasses
☐	☐	double or blurred vision
☐	☐	worsening vision
☐	☐	eye pain or itching
☐	☐	watering eyes
☐	☐	dry eyes
☐	☐	frequent infections

Y	N	**EARS**
☐	☐	hearing difficulties
☐	☐	frequent earaches
☐	☐	ringing/buzzing in ears
☐	☐	motion sickness
☐	☐	frequent infections
☐	☐	dizzy spells

Y	N	**NOSE AND THROAT**
☐	☐	sinus drainage
☐	☐	congestion
☐	☐	sneezing spells
☐	☐	allergies/hay fever
☐	☐	head colds
☐	☐	frequent nose bleeds
☐	☐	frequent sore throat
☐	☐	voice changes

Y	N	**RESPIRATORY**
☐	☐	wheezes or gasps
☐	☐	coughing spells
☐	☐	coughing up phlegm
☐	☐	coughing up blood
☐	☐	chest colds
☐	☐	history of Asthma/wheezing
☐	☐	history of COPD
☐	☐	pneumonia/ pleurisy
☐	☐	chronic cough

Y	N	**CARDIOVASCULAR**
☐	☐	high blood pressure
☐	☐	heart murmur
☐	☐	heart palpitations
☐	☐	irregular pulse
☐	☐	swollen ankles
☐	☐	varicose veins
☐	☐	shortness of breath
☐	☐	- at rest?
☐	☐	- with exertion?
☐	☐	- at night?
☐	☐	- laying down?

Y	N	**BREAST**
☐	☐	lump or pain
☐	☐	nipple discharge
☐	☐	monthly breast exams
☐	☐	chronic itching
☐	☐	redness or scaling
☐	☐	dimpling or puckering

Y	N	**DIGESTIVE**
☐	☐	difficulty swallowing
☐	☐	indigestion/heartburn
☐	☐	bloating/belching
☐	☐	nausea
☐	☐	vomited blood
☐	☐	abdominal pain
☐	☐	Diverticulosis
☐	☐	Crohn’s
☐	☐	bloody or tarry stools
☐	☐	change in bowel habits
☐	☐	constipation
☐	☐	loose stools/ diarrhea
☐	☐	Jaundice (yellow skin)
☐	☐	Hepatitis
☐	☐	hemorrhoids
☐	☐	hernia

Y	N	**URINARY**
☐	☐	frequent infections
☐	☐	painful urination
☐	☐	blood in urine
☐	☐	loss of control
☐	☐	frequent urination
☐	☐	nighttime urination
☐	☐	kidney stones
☐	☐	urinary urgency
☐	☐	discolored urine
☐	☐	foul smelling urine

Y	N	**FEMALE GENITAL**
☐	☐	birth control problems
☐	☐	recent vaginal itching
☐	☐	recent vaginal discharge
☐	☐	abnormal periods

Y	N	**MALE GENITAL**
☐	☐	difficult starting urine
☐	☐	prostate trouble
☐	☐	burning or discharge
☐	☐	lumps on testicles
☐	☐	impotency
☐	☐	loss of erections
☐	☐	hernias

Y	N	**MUSCULOSKELETAL**
☐	☐	aching muscles or joints
☐	☐	back or shoulder pain
☐	☐	leg pain while walking
☐	☐	foot pain
☐	☐	Gout
☐	☐	Arthritis
☐	☐	back pain
☐	☐	muscle weakness

Y	N	**SKIN**
☐	☐	recent hair loss
☐	☐	skin problems
☐	☐	itching or burning skin
☐	☐	leg or foot ulcers
☐	☐	bleeds easily
☐	☐	bruises easily
☐	☐	rash
☐	☐	Eczema
☐	☐	Psoriasis

Y	N	**NEUROLOGIC**
☐	☐	fainting spells
☐	☐	lightheadedness
☐	☐	dizziness
☐	☐	history of seizures
☐	☐	confusion/ memory loss
☐	☐	difficulty walking
☐	☐	tremors/ hands shaking
☐	☐	numbness/ tingling

Y	N	**MOOD**
☐	☐	anxious/nervous
☐	☐	lonely/depressed
☐	☐	cries often
☐	☐	hopeless outlook
☐	☐	trouble relaxing
☐	☐	worries a lot
☐	☐	frightening thoughts
☐	☐	loses temper
☐	☐	mental illness?
☐	☐	past suicide attempts
☐	☐	suicidal thoughts

History Reviewed
Clinician’s Signature ____ Date: ____________________________