PATIENT INFORMATION FORM

Patient Name_____ **Date of Birth** _____

Home Address:_____ **Zip Code**_____

Home Phone:_____ **Cell Phone:**_____ **Work Phone:**_____

Which number is the best number to reach you at? ☐ Home ☐ Cell ☐ Work.

Social Security #_____ **Sex : Male/Female Marital Status:**_____

Is the patient under 18 years of Age? Yes / No If, yes parents name_____

Race: (Circle One) White African American American Indian Alaskan Native Asian Native lslander
Ethnicity: (Circle One) Not Hispanic or Latino Hispanic or Latino

What Language do you speak: English Other:_____

Is the Patient Employed? YES / NO Full Time / Part Time Student? YES/ NO Full Time/Part Time
Name and Address of Employer:

_____

Name and Address of the Responsible Party: (Person who holds the insurance) ☐ **Self**

_____

Responsible Party Date of Birth:_____ **Social Security #**_____
Responsible Party Employer Name and Address:

_____

Name and Address of Pharmacy:_____
Allergies to Medicine? _____
Is this a Workers Compensation or Motor Vehicle Accident? Yes No Date of Injury? _____
If yes, Insurance Company? _____
Were you seen in an Emergency Room? Yes No Where?_____ **When:**_____
Did another doctor refer you to us? Yes No Who:_____
Who is your family Doctor? _____
Do you Smoke or Chew Tobacco? YES NO Have you tried medications to stop? YES NO

Emergency Contact:_____ **Phone #**_____
Relationship:_____

ASSIGNMENT OF BENEFITS/ AUTHORIZATION TO TREAT: **I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf, or to myself. I understand that I am financially responsible for all charges not covered by my insurance.**

Signature of the Patient or Responsible Party: _____**Date**_____

PATIENT NAME:_____ DATE:_____
NAME OF FAMILY PHYSICIAN:_____
Height:_____ Weight:_____ Age:_____

Are you allergic to or have you reacted adversely to:
Local Anethestics (Xylocaine) Yes No Please list_____
Penicillin or Antibiotics? Yes No Please list_____
Codeine or Pain Medication? Yes No Please list_____
Aspirin? Yes No Please list_____
Other : Please list:_____
Medications you take on daily basis. (If you have a list please present it to the receptionist).
_____
Current Medical Problems: (Example: High Blood Pressure, Diabetes, Heart Disease.)
_____
Previous Surgeries:
_____

Are you pregnant? Yes No Due Date:_____

Social History:

Are you a smoker?	Yes	No	How many years? _____	Have you tried to stop?	Yes	No
Do you drink Alcohol?	Yes	No	How many years? _____	Have you tried to stop?	Yes	No
Use Illegal Drugs?	Yes	No				

Family History: **Do you have a family member that has any of the following medical conditions?**
___ Heart Disease _____ ___ Diabetes _____
___ Cancer _____ ___ Stroke _____

Have you ever had any of the following? (Circle any that apply):

Skin:	Rashes	Tattoos	Skin Cancers	
Eyes:	Cataracts	Glaucoma	Glasses/Contacts	
Ears:	Dizziness	Hearing Aids	Ringing in the Ears	
Nose:	Allergies	Sinus Problems		
Mouth/Throat:	Dentures	Open Sores		
Endocrine:	Diabetes	Goiter	Thyroid Problems	
Cardiac:	Chest Pains	High Blood Pressure	Heart Disease	
Pulmonary:	Asthma	COPD	Shortness of Breath	TB Exposure
GI:	GERD	Ulcers	Nausea/Vomiting	Blood in Stool
GU:	Painful Urination	Blood in Urine	Frequency	Kidney Disorder
Musculoskeletal:	Joint Pain	Arthritis	Gout	Fractures
Neurological:	Epilepsy	Fainting Spells	Numbness	
Hematologic:	Anemia	Sickle Cell Disease	Circulation problems of feet or legs	
Psychiatric:	Insomnia	Depression	Psych admits	
Other:	Cancer	HIV/AIDS	Hepatitis	Excessive Weight Change

Patient Signature:_____ Date_____

AUTHORIZATION TO TREAT

I hereby authorize Charles P. Capito, M.D. to administer such treatment and perform such procedures as may be deemed necessary or advisable in the diagnosis of this patient.

X_____ Date_____

Signature of patient or responsible party

SELF PAY/CO-PAY/DEDUCTIBLE

I am responsible for my co-pay at the time of the visit and for any deductible after payment is made by the insurance company. I understand that if I have no medical insurance, I will be held responsible for any services rendered by Charles P. Capito, M.D.

X_____ Date:_____

Signature of patient or responsible party

FAX TRANSMISSION AUTHORIZATION

In certain circumstances it may be necessary for Charles P Capito, M.D. to fax your medical records to another physician's office, insurance company or legal firm. We would like your authorization to do so.

I understand that is many be necessary for you to transmit my medical records electronically, and I authorize you to do so. I absolve Charles P. Capito, M.D. of any liability relating to the submission of these records.

X_____ Date:_____

Signature of patient or responsible party

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this is voluntary.

Patient Name:_____ Date of Birth:_____

One receiving the information	Information being provided by:
Charles P. Capito M.D.	_____
703 Colliers Way	_____
Weirton, WV 26070	_____
Fax: (304) 723-5638	_____

Specific description of the information and reason for the request:

Patient Signature _____ Date_____

Charles P. Capito, M.D.

703 Colliers Way
Weirton, WV 26062
(304) 723-3355

2315 Sunset Blvd., Suite C
Steubenville, OH 43952
(740) 266-9411

Patient Privacy Release

I authorize Charles P. Capito, M.D. to **release/receive** medical information **to/from** my family physician **or any other physician or hospital who participates in my care:**
Yes☐ No☐ Family Physician_____

Please list any family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis.

Please list the family members or significant other and their phone number whom we may inform about your medical condition **only in an emergency.**

Please print the address where you would like your billing statements and/or correspondence from our office to be sent **if other than your home.**

Please print the telephone number, if any, where you would like to receive calls about your appointments or other health care information **if other than your home phone.**

Can confidential messages (i.e. appointment reminders, time/date changes) be left on your home answering machine or voicemail? Yes☐ No☐

If you do not have voicemail, can a confidential message be left at your place of employment? May we call there and ask you to call the office? Yes☐ No☐

I verify that my address, phone number, and insurance are the same as my last visit (if I had a previous appointment). If not, the change is:

Do you have an advanced directive (a living will)? Yes☐ No☐
Are you aware that you have the right to form/choose an advanced directive (a living will)?
Yes☐ No☐

Signature_____ Date_____

Signature of guardian if under 18 years_____ Date_____

Witness:_____ Expires_____

We will not release any information to a family member or friend not listed on this form.