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 Islander
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:________________

<u>Social History:</u>

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

<u>Family History:</u> **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.