Midtown Medical

PATIENT INFORMATION

First Name/Nombre:	Middle Initial	Last /Apellido:	Patient Account Number:
Street Address/Direccion:	City/Ciudad:	State/Estado:	Zip/Codigo Postal:
Home Phone/# Casa:	Work Phone/Trabajo:	Cell Phone/# Celular:	
Sex: ☐ Female ☐ Male	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other	Date of Birth/Fecha de Nacimiento:	Age/Edad:
Social Security Number/Seguro Social:	Referred by: (Doctor)/Referido Medico:	(Attorney)/Abogado:	Spouse Name/Espso/a:
IN CASE OF EMERGENCY - Contact:		Relationship:	
Home Phone:		Work Phone:	

HEALTH INSURANCE INFORMATION

Primary Insurance Company Name:		Telephone #:	
Insurance Address:	City:	State:	Zip:
Policy Holder Name:	Identification #:		
Policy Holder Birth Date:	Group#:	Additional Info:	

AUTOMOBILE ACCIDENT INFORMATION

Date of Accident/Fecha de Accidente:	Med Pay? ☐ Yes ☐ No	If yes, how much? $	
Insurance Company:	Address:	City/State:	
Adjuster Claim Rep:	Claim #	Phone #:	

WORKERS' COMPENSATION INFORMATION

Date of Accident:	Employed By:	Phone #:
Insurance Company:	Address:	City/State:
Adjuster	Claim #	Phone #:
Claim Rep:		

OTHER ACCIDENT / INCIDENT INFORMATION

Other Accident/Incident Type (Describe Briefly):		
Insurance Company:	Address:	City/State:
Adjuster:	Claim #	Phone #:

ATTORNEY INFORMATION

Firm Name/Nombre de Firma:	Attorney Name/Abogado:	Phone #:
Address:	City/State:	Zip:

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hearby authorize payment of surgical and/or medical benefits to be paid directly to the physician, if any, otherwise payable to me for his/her services as described realizing that I am responsible to pay non-covered services. I further authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

Signature/Firma _____ Date/Fecha _____

Office Use Only (D/A) _____ (DX) _____

Midtown Medical

Date_____

PATIENT MEDICAL INFORMATION

Patient Name_____Patient Account Number_____

List all medications that you were taking before the accident.

_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, which medication(s)?_____

Date of Last Medical Exam: _____ with whom? _____

LIST OF MAJOR SURGERIES

_____ Date: _____

_____ Date: _____

Have you had any major falls or accidents (automobile) in the past 3 years? Please describe below:

_____

SOCIAL AND OCCUPATIONAL HISTORY

Employed by:_____ ☐ Unemployed ☐ Housewife ☐ Student

Type of work:_____

# of children and ages:_____

(1.) Do you smoke cigarettes/tobacco? ☐ Yes ☐ No

(2.) Do you use any illegal substances? ☐ Yes ☐ No

(3.) Do you consume alcohol? ☐ Yes ☐ No ☐ Occasional

(4.) Are you HIV+/AIDS? ☐ Yes ☐ No

FEMALES ONLY

Date of last menstrual cycle _____

Is there a possibility you may be pregnant? ☐ Yes ☐ No

If yes, due date_____

Currently taking birth control pills? ☐ Yes ☐ No

Currently taking hormone replacement? ☐ Yes ☐ No

PREVIOUS ILLNESSES

Please advise which of the following conditions you have ever had.

ASTHMA:	SEIZURES:	NERVOUS CONDITIONS:
ARTHRITIS/BACK PAIN:	HEART PROBLEMS:	MENTAL ILLNESSES:
DEPRESSION:	DIABETES:	CANCER:
HIGH BLOOD PRESSURE:	STROKE:	HEADACHES:

FAMILY HISTORY

Has your mother or father had any of these above conditions?

Mother: _____

Father: _____