www.medicalhousecalls.com
57190 Main Rd, Southold, NY 11971
info@medicalhousecalls.com

Medical: 631-626-1006
Physical Therapy: 631-765-3620
Fax: 631-477-6219

Date:____________

New Patient Form

First Visit Date:______________

PATIENT INFORMATION

Name:__________________________________

Street:__________________________________

Facility/Complex__________________________

____

Town/State/Zip:___________________________

____

Contact Information:

Phone:__________________________________

Email:__________________________________

Date of Birth________/________/_________

Sex: M F

Soc Security #:____________________________

Emergency Contact Information

Name___________________________________

Phone___________________________________

Relationship:______________________________

Name:___________________________________

Phone:___________________________________

Relationship:______________________________

Responsible Party Billing address

(If not same as above)

Name:___________________________________

Street:___________________________________

Town/State/Zip:____________________________

PRIMARY INSURANCE

Insurance Company:____________________________

Claim Address:_________________________________

City/state/Zip:_________________________________

Group #:______________________________________

Policy/ ID# :___________________________________

Name on Card:_________________________________

Date of Birth:_________________________________

Soc Security #:________________________________

Effective Date:_________________________________

SECONDARY INSURANCE

Insurance Company:______________________________

Claim Address:__________________________________

City/state/Zip:__________________________________

Group #:_______________________________________

Policy/ ID# :____________________________________

Name on Card:__________________________________

Date of Birth:___________________________________

Soc Security #:__________________________________

Effective Date:__________________________________

Other Physicians

Name:____

Phone:____

Fax:_______________Specialty_____________________

Name:____

Phone:____

Fax:_______________Specialty_____________________

www.medicalhousecalls.com
57190 Main Rd, Southold, NY 11971
info@medicalhousecalls.com

Medical: 631-626-1006
Physical Therapy: 631-765-3620
Fax: 631-477-6219

Past Medical History

Have you ever been Hospitalized? ☐Yes ☐No If yes, why?___________________________

Have you ever been treated for Hepatitis A,B, or C ☐Yes ☐No If yes, which?__________________________

Have you been vaccinated for Hepatitis B? ☐Yes ☐No If yes, date

complicated:________________

Have you been vaccinated for Hepatitis A? ☐Yes ☐No If yes, date complicated:________________

Last Tuberculosis (TB) Screening?_________________________ Result of screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray:________________ Result of Chest Xray: ☐Positive ☐Negative

Have you ever had a sexually Transmitted Disease? ▫Yes ▫No Diagnosis:____________________________

Which of the following conditions are you currently being treated for or diagnosed with in the past? (Please check)

☐Heart disease / Murmur / Angina	☐High cholesterol	☐High blood pressure
☐Low blood pressure	☐Anemia or blood problems	☐Swollen
☐Heartburn (reflux)	☐Shortness of breath	☐Asthma
☐Sinus problems	☐Seasonal allergies	☐Tonsillitis
☐Ear problems	☐Lung problems / cough	☐Eye disorder / Glaucoma
☐Seizures	☐Head aches / Migraines	☐Neurological problems
☐Depression / Anxiety	☐Psychiatric care	| Stroke
☐Diabetes	☐Kidney / Bladder problems	☐Liver problems / Hepatitis
☐Arthritis	☐Cancer	☐Ulcers/colitis
☐Thyroid problems		

Please Describe any current or past medical treatment not listed above

____

____

www.medicalhousecalls.com
57190 Main Rd, Southold, NY 11971
info@medicalhousecalls.com

Medical: 631-626-1006
Physical Therapy: 631-765-3620
Fax: 631-477-6219

Please list your past surgeries

____

____

Allergies

Are you Allergic to penicillin or other drugs? ☐Yes ☐No

Please list:____

Have you ever had to use an Epinephrine Pen? ☐Yes ☐No If Yes, date administered:_______________

Medications: (PLEASE LIST ALL MEDICATIONS)

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

Social and Preventive History

Do you currently smoke or chew tobacco?	☐Yes ☐No	If no, have you in past?	☐Yes ☐No
Do you drink alcohol, beer, or wine?	☐Yes ☐No	If no, have you in past?	☐Yes ☐No
Do you currently drink coffee or tea?	☐Yes ☐No	If yes, how many cups per day?___________	
Do you wear a helmet when riding bike?	☐Yes ☐No	Do you exercise weekly?	☐Yes ☐No
Do you wear seatbelt when driving?	☐Yes ☐No		

Family History

	Living	Age (or age of death)	List of serious illness
Mother	☐Yes ☐No	________________	____________________________________
Father	☐Yes ☐No	________________	____________________________________
Sisters	☐Yes ☐No	________________	____________________________________
	☐Yes ☐No	________________	____________________________________
Brothers	☐Yes ☐No	________________	____________________________________
	☐Yes ☐No	________________	____________________________________

www.medicalhousecalls.com
57190 Main Rd, Southold, NY 11971
info@medicalhousecalls.com

Medical: 631-626-1006
Physical Therapy: 631-765-3620
Fax: 631-477-6219

Has any member of your family (including children and parents) had any of the following illness:

Illness	**Which family member(s)**
Anemia or blood disorder	___________________________________
Cancer	___________________________________
Diabetes	___________________________________
Glaucoma	___________________________________
Heart Disease	___________________________________
High Blood Pressure	___________________________________
HIV disease/ AIDS	___________________________________
Mental Status/ Depression	___________________________________
Stroke	___________________________________
Other serious illness	___________________________________

Females: Do you routinely see OBGYN? ☐Yes ☐No

How many times have you been pregnant?___________________ Date of last Pap Smear:_________________

Have you had an abnormal Pap smear? ☐Yes ☐No Diagnosis:_____________________________

Date of last Mammogram:__________________________ Mammogram results:____________________

Have you ever had a breast biopsy?☐Yes ☐No Biopsy results:_________________________

By signing below, I certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate. I hereby give consent for medical treatment. I have read the comprehensive patient information and I agree, as per company guidelines, Medical House Calls of the North Fork reserves the right to begin the immediate discharge of any patient if any of the following occur; abuse including physical and/or verbal, sexual innuendo, threatening communications, or assault by the patient or any family members.

Patient/ Legal Guardian Signature____ Date:__________________