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Health Professionals of Winfield
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Dear Patient,

In an effort to be efficient with your time and ours, as well as to establish the type of care you may need; we require this paperwork to be filled out in advance of booking your first appointment with us.

We do not usually schedule patients that are under the age of seven, as they would be better fit with a pediatrician or a family practitioner. We also are not a pain management clinic, and if you are on narcotics for chronic pain you would be a better fit with a pain management physician.

The more information we have before your appointment, the better we can serve your needs. Please fill these out to the best of your ability, so that our staff may enter the information in our computer system. You may need to refer to your medicine bottles to note the correct spelling and dose of your current meds. Any omission of information concerning your health may prevent you from becoming a patient of Health Professionals of Winfield.

Upon completion of these, please mail or drop off at our office, along with a copy of your current medical insurance card and we will contact you to set up an appointment. Please be advised that you should NOT transfer your medical records to us at this point. You need to remain with your current physician until we have determined if and when your transfer to our office will happen.

Health Professionals of Winfield

Welcome to Our Office!

Patient Information:

Name: _____

Address: _____ _____ _____ _____
Street City, state, zip

Gender: M__ F___ Marital status: S___ M___ W___ D___ Separated___ Date Of Birth _____

Social Security Number: _____ Race _____ Age: _____

Who may we thank for referring you to us? _____

Home Phone: _____ Work Phone _____

Cell Phone: _____ E-mail _____

Employer Name: _____

Name of nearest friend or relative: _____ His/her Phone #: _____

Address _____ Relationship: _____

Guarantor Information: (To whom will the bill be sent after insurance, if any)?

Name: _____

Address: _____ _____ _____ _____
Street City, state, zip

Birth date _____ Social Security Number: _____

Home Phone: _____ Work Phone _____

Cell Phone: _____ E-mail _____

Employer Name: _____

Insurance Information: (If you have your card with you, please present it to registration staff)

Insurance Co: _____

Policy #: _____ Group # _____

Subscriber Name: _____

Subscriber Date of Birth: _____

☐ Please check if NO insurance

2nd Ins Name _____

2nd Policy # _____

Subscriber Name: _____

Subscriber Date of Birth: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I authorize the release of any information required for claim(s) submission to my insurance company(s). I also authorize that payments be made directly to the provider.

Signature: _____ Date: _____

Parent, if minor: _____ Date: _____

Patient Name: _____ DOB _____

I authorize for my information to be released to the following person(s) *if he or she so requests:*

Person & relationship: _____

Person & relationship: _____

Person & relationship: _____

Person & relationship: _____

Medication	Dosage	Directions	Quantity	office use

Preferred Pharmacy: _____

Allergies: _____

Patient Name: _____ DOB _____

Date	Problem List - resolved or ongoing?	Date	Previous Hospitalizations or Surgeries
		Date	Consultants: current / past

	Frequency	Last Time was?	When did you last have the following?	
Tobacco Use?			TD	
Alcohol Use?			Flu	
Drug Use?			Pneumonia	
Exercise?			Hepatitis B	
Family History	List Family Member/Relation		TB Skin test (PPD)	
Heart Attack			Colonoscopy	
Stroke			PSA	
Heart Disease			Prostrate Exam	
High BP			Pap	
Diabetes			Breast Exam	
Cancer			Mammogram	
Other			TSH	
			Lipids	
Do you have a Living Will?			HgA1C	
Do you have a DNR?			Microalbumin	
Are you a registered Organ Donor?			Eye Exam	
			Foot Exam	