PROVIDER:

Dr. Christie Skinner, DNP Anita Burleson, ANP

Health History

Patient Name: _____

DO YOU HAVE A PERSONAL HISTORY OF…

☐ DIABETES (E11.9)	☐ COPD (J44.9)	☐ BLOOD PRESSURE (I10)	☐ CROHNS DISEASE (K50.10)
☐ HEART DISEASE (I51.9)	☐ TUBERCULOSIS (A15.9)	☐ DIVERTICULITIS (K57.90)	☐ KIDNEY STONES (N20.2)
☐ HEART ATTACK (I21.3)	☐ LIVER DISEASE (K76.9)	☐ ULCERATIVE COLITIS(K51.90)	☐ SEIZURES (R56.9)
☐ HIGH CHOLESTEROL (E78.5)	☐ THYROID DISEASE (E07.9)	☐ ASTHMA (J45.998)	☐ AIDS/HIV (B20)
☐ STROKE (I63.9)	☐ HEPATITIS (K71.6)	☐ MIGRAINES (G43.009)	☐ CHRONIC PAIN* (G89.29)
☐ CANCER (C80.1)	☐ BACK INJURY (S39.92XA)	☐ ULCERS (K12.1)	☐ KIDNEY DISEASE (N28.9)

History of surgeries (please include year): _____

_____

_____

Medication Allergies: _____

Do you use tobacco? _____Type and amount: _____

Do you drink alcohol? _____ Amount and frequency: _____

Have you ever been treated for drug or alcohol abuse? _____

FAMILY HISTORY (PLEASE LIST ANY SIGNIFICANT HEALTH CONDITIONS)

FATHER: _____

MOTHER: _____

GRANDPARENTS: _____

SIBLINGS: _____

*PLEASE NOTE: SKINNER FAMILY PRACTICE DOES NOT PROVIDE PAIN MANAGEMENT.
PLEASE INITIAL HERE INDICATING YOUR UNDERSTANDING OF THIS: ____ DATE: _____

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DEMOGRAPHIC INFORMATION

First: _____MI: _____ Last: _____
Preferred Name: _____Maiden name: _____
Social Security #:_____ Date of Birth: _____ Gender: _____
Marital Status: _____ Ethnicity (optional): _____
Home Address: _____
City: _____State: _____ Zip: _____
Phone: _____ Mobile: _____ Other: _____

Emergency Contact: _____
Relationship: _____ Phone: _____

Preferred pharmacy: _____

Please list other family members that are patients at Skinner Family Practice:

_____
_____
_____

RESPONSIBILITY OF PAYMENT:

Please list the person responsible for your medical bills. If your insurance is not in your name, this section is mandatory.

Name: _____
Social Security #: _____ Date of Birth _____ Gender: ____
Address: _____
City: _____ State: _____ Zip: _____
Relationship: _____

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INSURANCE INFORMATION

Patient Name:_____

Please provide a copy of your card for our files.

If you have NO insurance, please indicate by initialing here: _____. By initialing, you accept responsibility for all amounts billed for services provided. Payments are due at the time of service. If other services are provided, billing may be delayed and therefore payment will be expected upon receipt of the final bill.

Primary Insurance: _____

Name of insured: _____

Insured date of birth: _____ Insured SS#: _____

Relationship to insured: Self/ Spouse / dependent / other

Secondary Insurance: _____

Name of insured: _____

Insured date of birth: _____ Insured SS#: _____

Relationship to insured: Self/ Spouse / dependent / other

Authorization and assignment:

I hereby authorize Skinner Family Practice to furnish any information to my insurance carrier(s) and health care administrators or agents concerning my illness and/or treatment. I hereby assign to Skinner Family Practice all payments for services rendered to me/my covered dependents. I understand that I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED BY INSURANCE AND THAT MY COPAYMENT IS DUE AT THE TIME OF SERVICE. I further understand that Skinner Family Practice is filing my insurance as a courtesy and convenience for me and that I am ultimately responsible for all billed amounts for services provided.

Signature: _____ Date: _____

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HIPPA PRIVACY ACT

Patient Name:_____

By signing below, I acknowledge that I have been notified of the availability of the Notice of Privacy Practices and a copy has been made available to me by Skinner Family Practice. I also authorize Skinner Family Practice and any authorized staff members to share pertinent protected health information with those listed below. I also understand that, with written request, I can amend or withdraw any names listed below at any time and that it is my responsibility to ensure the persons listed below do not divulge or use the information provided in any way without my authorization.

Please list below any individuals to which health information may be freely shared without further notification. Please DO NOT list other physicians of medical facilities.

By initialing here, I am requesting that NO ONE receive health information about me without advanced notice by me. Initials: _____Date: _____

The following individuals may freely receive any information regarding my health without further notice…

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

SKINNER FAMILY PRACTICE

PROVIDER:

Dr. Christie Skinner, DNP　　　　Anita Burleson, ANP

MEDICATION LIST

Medication Name:	Dosage:	How taken: