Mountain Laurel Family Practice

Please complete all sections in legible print.

PERSONAL INFORMATION

Name-Last_____First_____MI_____

Date of Birth_____ Gender_____ Martial Status_____

Address_____ City_____ State/Zip_____

Phone-Home_____ Work_____ Cell_____

Email_____

SS#_____Employer_____

Emergency Contact: (Name/Phone#/Relationship)_____

Insurance Information Please provide a copy of your insurance card so we can accurately enter your information.

Ethnicity: (Please check one.)

- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino
- ☐ I do not wish to specify my ethnicity

Preferred language:_____

Race: (Please check one.)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ I do not wish to specify my race

Preferred communication: (Please check one.)

- ☐ Home Phone
- ☐ Cell Phone
- ☐ Work Phone
- ☐ Email
- ☐ Other _____

Individual Medical Release Please list all individuals that we are authorized to provide information to. This release will authorize us to provide medical information, appointments, billing information, etc. with all individuals listed below. Any change in the authorization must be made to MLFP staff and be initialed and dated by both MLFP staff and the patient.

Name/Relationship_____

Name/Relationship_____

Name/Relationship_____

Patient Signature_____ Date_____

Mountain Laurel Family Practice
Patient Health History

Name: _____ Date: _____

Date of birth: _____

Past Medical History

Previous surgeries (list type and date/year of surgical procedures; approximate dates are acceptable):

_____

_____

_____

_____

Past hospitalizations (list date and reason for hospitalization):

_____

_____

_____

_____

Specialist care in the last 5 years (list provider's name and reason for care):

_____

_____

_____

Diagnostic testing (list previous x-rays, MRI, and CT scans and the reason that they were performed):

_____

_____

_____

Ongoing health issues (conditions for which you have been treated > 3 months):

_____

_____

Medication Allergies (include medication and type of adverse reaction):

_____

_____

Current medications (include all prescription, over-the-counter medications, vitamins, and supplements):

_____

_____

_____

_____

Family History
Limit history to parents, grandparents, siblings, and children; list who had each condition, if relevant.

High blood pressure: _____

Diabetes: _____

Cancer (include type): _____

Stroke: _____

Heart attack/cardiovascular disease: _____

Depression/anxiety/mental illness: _____

Asthma/allergies: _____

Preventative Healthcare

Last wellness exam/physical: _____

Lab work: _____

Eye exam: _____

Dental exam: _____

Mammogram: _____

Pap smear: _____

Bone density (DEXA scan): _____

Colonoscopy: _____

Foot exam (if diabetic): _____

Social History (indicate type, amount, and duration of use)

Tobacco (oral and/or cigarettes/cigars): _____

Alcohol: _____

Street/elicit drugs: _____

Caffeine: _____

Wellness

Exercise (number of days/week and type of exercise): _____

_____

Diet (dietary restrictions or specific diet followed): _____

_____

Flu vaccine: _____

Tetanus (TDAP vaccine): _____

Pneumonia vaccine: _____

Shingles (zoster) vaccine: _____

Other recent vaccinations received: _____

Employment (what do you do for a living?): _____

Who do you live with? _____

Are there any specific health concerns that you would like to address during your office visit today?

_____

_____

_____

On the day of your office visit

MLFP office policies 8/2015

1- please arrive 15 minutes prior to visit so that you are ready for your appointment time

2- please bring a current medication list or your medication bottles to each visit

3- bring current insurance card and co-payment to every visit

4- for cash paying patients- be prepared to pay on the day of your visit or make arrangements BEFORE you are seen

Between office visits

5- Refills are issued during visits and it is YOUR responsibility to follow up before you are out of medications.

- **We will charge a $10 refill fee if you need refills and are overdue for follow up.**

6- Controlled medications are only filled at office visits and will not be issued unless seen

7- Antibiotics will not be issued over the phone-unless recently seen for a related issue.

Expectations

8- All patients are allowed ONE no show appointment and if a second occurs we will not be able to see you as a patient in the future

- **All patients are charged $25 for this "one time" no show appointment.**

9- We request a 24 hour notice on cancellations, so that we may give someone else the opportunity to be seen

These updated policies were created with the intent to improve our time management and to give us more time with our patients face to face

Please let us know if you have any questions

_____ pt sig _____ witness _____ date