Pedersen Primary Care

290 S. Alma School Road, Suite 5
Chandler, Arizona, 85224

Personal Information

Name: _____ Date of Birth____/____/_____
Last First MI MM/DD/YYYY

Address: _____ Gender: Male/Female Age: _____
Street

_____ Marital Status: S M D W
City State Zip Social Security #: ___-___-_____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Occupation: _____

Primary Language: _____ Race: _____ Ethnicity: _____

How did you hear about our office? _____

Insurance Information

Primary Insurance: _____ ID/Policy Number: _____

Group#: _____ Policy Holder/Guarantor: _____ DOB: ___/___/___
MM/DD/YY

Address: _____ Phone: _____
Street City State Zip

Secondary Insurance: _____ ID/Policy Number: _____

Group#: _____ Policy Holder/Guarantor: _____ DOB: ___/___/___
MM/DD/YY

Address: _____ Phone: _____
Street City State Zip

Emergency Contact Person

Name: _____ Phone: _____ Relationship to patient: _____

Pharmacy Information

Name: _____ Cross Streets: _____ Phone: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires us to ask you:
Do we have permission to discuss your case with certain specified relatives and/or friends of your choosing:

Spouse? Yes No Name: _____ Others? Name/Relationship: _____

Do we have your permission to leave messages on your voice mail at home/work or cell? Yes No
I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office accordance with the regular rates and payment terms of this office. In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release records of my treatment to my insurance company or third party responsible for my payment of my medical charg

Patient/Guardian Signature: _____ Date: _____

Print Full Name: _____

Name of Patient: _____ Date: _____

MEDICATIONS

List all current prescription, non-prescription medications, vitamins, and herbal products. Please INCLUDE even occasional use of aspirin or anti-inflammatory medication for arthritis.

Name of Medication	Strength	Frequency Taken

PATIENT'S MEDICAL HISTORY (active or inactive) Circle those that are applicable

Angina	Gall Stones	Kidney Stones
Anemia	Heart Attack	Chronic Kidney Disease
Coronary Artery Disease	Congestive Heart Failure	Migraine Headaches
High Blood Pressure	Colitis	Diabetes/High Sugar
Stomach Ulcers	Heart Valve Disease	Seizures
Acid Reflux, GERD	Atrial Fibrillation	Pancreatitis
Thyroid Disease	Osteoporosis	Hepatitis
-CANCER-	Stroke	Colon Polyps
Breast	High Cholesterol	Rheumatoid Arthritis
Skin	Hay Fever	Degenerative Arthritis
Prostate	Asthma	Glaucoma
Colon	COPD; Emphysema	Depression
Other: _____	Sleep Apnea	Bipolar Disorder

Other medical problems not listed above:

_____

_____

Preventive Medicine Screening Tests (check all that apply – most recent month and year):

____ Colonoscopy	_____ (month & year)	____ PAP Smear	_____ (month & year)
____ Mammogram	_____ (month & year)	____ PSA /Prostate Exam	_____ (month & year)
____ Cholesterol test	_____ (month & year)	____ Exercise Stress Test	_____ (month & year)

Immunizations:

____ Pneumonia	_____ (month & year)	____ Measles	_____ (month & year)
____ Chicken Pox / Shingles	_____ (month & year)	____ Tetanus	_____ (month & year)
____ Hepatitis A	_____ (month & year)	____ Flu	_____ (month & year)
____ Hepatitis B	_____ (month & year)	____ Meningococcal	_____ (month & year)

ALLERGIES ☐ NONE

INCLUDE allergies to medications and other medical products (examples: tape, latex, and iodine).

Name of Medicine or Product:	Description of Reaction:

SURGICAL HISTORY ☐ None

Type of Surgery and Reason	Year

PREGNANCY HISTORY # of pregnancies: _____ # of children: _____

FAMILY HEALTH HISTORY

	AGE	HEALTH PROBLEMS/cause of death		AGE	HEALTH PROBLEMS/cause of death
Father		**Living:** ☐ Y ☐ N	**Children**		M F
Mother		**Living:** ☐ Y ☐ N			M F
Sibling		**Living:** ☐ Y ☐ N M F			M F
		Living: ☐ Y ☐ N M F			M F
		Living: ☐ Y ☐ N M F	**Grandmother** *Maternal*		**Living:** ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandfather** *Maternal*		**Living:** ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandmother** *Paternal*		**Living:** ☐ Y ☐ N
		Living: ☐ Y ☐ N M F	**Grandfather** *Paternal*		**Living:** ☐ Y ☐ N

HEALTH HABITS AND PERSONAL SAFETY Occupation: _____

EXERCISE: How often: _____ Which Activities: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, what kind? _____ How many drinks per week? _____
How often do you have 6 or more drinks on one occassion? _____

Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes – pks./day _____ # of years _____ ☐ or year quit _____

☐ Chew - #/day_____ Do you currently use recreational or street drugs? ☐ Yes ☐ No

I have received and read the clinic's Privacy Notice: _____ (initials)