SVH Family Care

Greetings!

We would like to welcome you to our practice. Enclosed you will find our registration forms. Please arrive **30 minutes** before your scheduled appointment with the **completed** registration forms. Should you have any questions regarding the completion of the forms, please contact the office at ***(207) 487-5154***.

Please bring the following to your appointment:

- A copy of your current insurance cards
- Social security card
- Immunization records (even if you're an adult)
- All medication you are taking, including over-the-counter medications
- Records from previous health care providers
- Completed registration forms

Our Office Policy

Payment is expected at the time of service. If your insurance requires a co-pay, that is also expected at the time of service, unless payment arrangements are made in advance. Every insurance plan covers Primary Care differently. Please call your insurance carrier to find out what your plan covers if there are any questions.

Thank you for choosing us for your healthcare needs.
If you have any questions for concerns, please call and we will help you any way we can.

Sincerely,
Sebasticook Regional Family Care

SVH
SEBASTICOOK VALLEY HEALTH
EMHS MEMBER

SVH Family Care

Patient Information Form

Date: ___/___/___ **First Name:** _____ **Last Name:** _____

Middle Initial: _____ **Previous Last Name:** _____ **Date of Birth:** ___/___/___

Social Security Number: ___-___-___ **Religious Preference:** _____

Mailing Address: _____

Physical Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: ( ) - _____ **Cell Phone:** ( ) - _____ **Work Phone:** ( ) - _____

May we leave a message on your answering machine or with the person who answers the phone? ☐Yes ☐No

Email Address: _____

Primary Care Provider: _____

Marital Status: (Please Check One) ☐ Single ☐ Married ☐ Divorce ☐ Widowed ☐ Separated

Directives: Do you have a living will? ☐ Yes ☐ No Would you like information about a will? ☐ Yes ☐ No

Patient Employer (Please Check One) ☐ Full Time ☐ Part Time ☐ Self-Employed ☐ Unemployed
☐ Student ☐ Retired: Date of Retirement: ___/___/___ ☐ Disabled: Date of Disability ___/___/___
Employer: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____ Business Phone: ( ) - _____

Emergency Contact #1 Relationship to Patient: _____
First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Home Phone : ( ) - _____
Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Emergency Contact #2 Relationship to Patient: _____
First Name: _____ Last Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Home Phone : ( ) - _____
Cell Phone: ( ) - _____ Work Phone: ( ) - _____

Insurance Information: (Please Check One) ☐ Self-Pay ☐ SVH Free Care ☐ MaineCare ☐ TriCare ☐ Champ VA
☐ Medicare Part A ☐ Medicare Part B ☐ Worker's Compensation ☐ Motor Vehicle Accident ☐ Other (Commerical)
Commercial Insurance Name: _____
Primary Insurance ID #: _____ Group #: _____
Secondary Insurance ID # : _____ Group #: _____

Guarantor: (Please Check One) ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____
** **If the guarantor is self, you do not have to fill out the rest of this section** **
First Name: _____ Last Name: _____
Address: _____ City: _____ State: _____
Zip Code: _____ Home Phone: ( ) - _____ Cell Phone: ( ) - _____
Work Phone: ( ) - _____

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Patient Medical History

Date: ____/____/____ **Name:** _____ **DOB:** ____/____/____ **Age:** _____

(Last, First, Middle Initial)

If you have ever had any of the following, please check the box:

☐ Allergies/Hay Fever/Sinusitis	☐ Goiter/Thyroid Problems	☐ Pneumonia
☐ Anemia or Low Blood	☐ Gout	☐ Rheumatic Fever
☐ Arthritis	☐ Heart Attack	☐ Seizures/Convulsions
☐ Asthma	☐ Heart Murmur	☐ Severe Headaches/Migraines
☐ Back Pain	☐ Hernia (Rupture)	☐ Stroke
☐ Blood Clot in Leg	☐ High Blood Pressure	☐ TB (Tuberculosis)
☐ Bronchitis	☐ High Cholesterol	☐ Ulcer
☐ Cancer/Tumor	☐ Kidney Stones	☐ VD/Gonorrhea/Syphilis
☐ Colitis/IBS/Constipation	☐ Kidney/Bladder Infections	☐ Yellow Jaundice
☐ Emphysema	☐ Leukemia	☐ Other _____
☐ Fractures	☐ Nervous Condition	_____

Any Known Drug Allergies? _____

Latex Allergy? ☐ **Yes** ☐ **No** **Food Allergy?** ☐ **Yes** ☐ **No**

If you do have food allergies, please list: _____

_____

Please list all prescription and/or nonprescription medications that you are currently taking:

(Please include herbal medications, supplements and vitamins)

Medication/Dosage:	How Often Taken:	Medication/Dosage:	How Often Taken:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dates of Immunizations (Adults):

Tetanus/Diptheria:____/____/____ TB/Tine Test:____/____/____ Flu:____/____/____ Hepatitis B:____/____/____

Rubella/German Measles:____/____/____ Pneumonia:____/____/____ Polio:____/____/____

Have you ever been hospitalized or had any surgical procedures?

Admit Date:	Reason for Admission/Surgery Type:
1.) ____/____/____	_____
2.) ____/____/____	_____
3.) ____/____/____	_____

Habits/Tendencies:

Do you smoke?	Yes	No	(amount per day)	Do you drink?	Yes	No	(amount per day)
Cigarettes	☐	☐	_____	Beer/Liquor/Wine	☐	☐	_____
Marijuana	☐	☐	_____	Coffee	☐	☐	_____
Cigars	☐	☐	_____	Tea	☐	☐	_____
Pipe	☐	☐	_____	Sode	☐	☐	_____

Are you employed? ☐ Yes ☐ No If yes, what is your current occupation? _____

How long have you been in this occupation? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Current:	**Yes**	**No**
Recent weight loss?	☐	☐
Intentional?	☐	☐
Recent weight gain?	☐	☐
Intentional?	☐	☐
Are you satisfied with your sex life?	☐	☐
Have you ever been abused?	☐	☐
Do you use drugs?	☐	☐
Do you exercise?	☐	☐
How many times/week? _____		
Do you have children?	☐	☐
How many children do you have? _____		

Women:
Age period started? _____
First day of last period? ____/____/____
Do you use birth control? ☐ Yes ☐ No
How long have you used birth control? _____
Have you ever been pregnant? ☐ Yes ☐ No
Number of pregnancies? _____

Sexuality: ☐ Partner of same gender ☐ Partner of opposite gender

Family History:	**Yes**	**No**	**Relationship**		**Yes**	**No**	**Relationship**
Alcoholism	☐	☐	_____	Heart Trouble	☐	☐	_____
Anemia	☐	☐	_____	High Blood Pressure	☐	☐	_____
Asthma/Hay Fever	☐	☐	_____	High Cholesterol	☐	☐	_____
Cancer/Tumor	☐	☐	_____	Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____	TB (Tuberculosis)	☐	☐	_____
Gallbladder Problems	☐	☐	_____	Thyroid Problems	☐	☐	_____
Glaucoma	☐	☐	_____	Other	☐	☐	_____

Explain: _____

Is there any other information you would like to share with us regarding your health status? ☐ Yes ☐ No
If yes, please explain below: _____