Rhode Island Medicine, Inc.
New Patient Information Form

NAME: _____ **DOB:** _____ **AGE:**_____ **SOC SEC**:_____

TEL (home):_____ (work/cell):_____ **EMAIL:** _____

ADDRESS: _____
Street City State Zip

PREFERRED PHARMACY:_____ **LOCATION:**_____

OCCUPATION: _____ **FULL TIME?**_____ **PART TIME?**_____

EMPLOYER INFORMATION:_____
Company Name Phone

_____
Street City State Zip

MARTIAL STATUS: [Please Circle One] (Single) (Married) (Divorced) (Widowed) (Separated)

If married, spouse's name:_____

Children's names/ages:_____

LANGUAGE:_____ **ETHNICITY: [Please Circle One] (**Hispanic) (Non-Hispanic)

RACE: [Please Circle One] (American Indian or Alaska Native) (Asian) (White) (Black or African American) (Native or Pacific Islander) (Other Race)

Do we have permission to release any of your medical information to any friend or relative? _____
If yes, please list below:

_____ _____
Name Relationship Name Relationship

EMERGENCY CONTACT (must have different contact information than you):

_____
Name Relationship Telephone

_____
Name Relationship Telephone

Do you or a spouse receive Veteran's Benefits? (YES) (NO)

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Insurance Company_____	Insurance Company_____
Membership No._____	Membership No._____
Account Holder _____	Account Holder_____
Relation to patient_____	Relation to patient_____
Soc Sec _____	Soc Sec _____
Tel_____	Tel_____
Address_____	Address_____
Employer Name _____	Employer Name _____
Address_____	Address_____

ALLERGIES TO MEDICATIONS, RADIOLOGIC DYES, OR OTHER SUBSTANCES: (Yes) (No)

If yes, please list name of medication and type of reaction: _____

_____ _____

_____ _____

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS: [Please circle if you are **PRESENTLY** complaining of any of the following]:

1. High Blood Pressure	13. Bronchitis	25. Ulcers	37. T.B.
2. Diabetes	14. Pneumonia	26. Changes in Bowel Habits	38. Arthritis
3. Cancer	15. Persistent Cough	27. Unexplained Weight Change	39. Asthma
4. Heart Disease	16. Difficulty Urinating	28. Hemorrhoids	40. Nausea
5. Chest pain/tightness	17. Hay Fever	29. Gall Bladder Disease	41. Vomiting
6. Shortness of Breath	18. Abdominal Discomfort	30. Alcohol Abuse	42. Anxiety
7. Swollen Ankles	19. Indigestion	31. Hepatitis or Jaundice	43. Depression
8. Palpitations	20. Skin Diseases	32. Thyroid Disease	44. Diarrhea
9. Lightheadedness	21. Venereal Diseases	33. Head or Neck Radiation	45. Aniema
10. Frequent Urination	22. Constipation	34. Headache	46. Colitis
11. Rheumatic Fever	23. Blood Disorders	35. Kidney Disease	47. Drug Abuse
12. Low Back Problems	24. Blood in Stool	36. Kidney Stones	48. Gout

Other Concerns/ Problems: _____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, Ect.):

Drug Name	Dose	Drug Name	Dose

Please List and Supply Dates of:

Operations: _____ _____

_____ _____ _____

Hospitalizations Other than Surgery: _____ _____

_____ _____ _____

Immunization History: Pneumovax (No) (Yes) When?_____ Flu (No) (Yes) When?_____

Hepatitis B (No) (Yes) When?_____ TDAP (No) (Yes) When?_____ Other:_____

FAMILY HISTORY: Has any member of your family (parents, grandparents, and siblings) ever had the following:

Illness	Which family members?	Age when diagnosed
Cancer (describe type)	_____	_____
High Blood Pressure	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental Health (anxiety, depression, ect)	_____	_____
Drug/Alcohol Addiction	_____	_____
Glaucoma	_____	_____
Bleeding Disease	_____	_____
Other: _____	_____	_____

WOMEN'S HEALTH:

Do you have a gynecologist? (No) (Yes) If yes, who do you see?_____

Age at onset of periods: _____ Frequency: _____ Length:_____

Pregnancies:_____ Births:_____ Miscarriages:_____

When was your last mammogram?_____ When was your last pap smear?_____

Prolonged or abnormal bleeding? (No) (Yes) Describe:_____

Pelvic Pain? (No) (Yes) Describe:_____

Leakage of Urine? (No) (Yes) Describe:_____

Abnormal Discharge? (No) (Yes) Describe:_____

History of abnormal Pap Smear? (No) (Yes) Treatment:_____

PREVENTION:

Do you currently smoke cigarettes? (No) (Yes) If yes, how many per day? _____

When did you start? _____ Are you interested in receiving help/information on quitting? (No) (Yes)

Have you ever smoked cigarettes? (No) (Yes) If yes, when did you quit? _____

Do you use drugs? (marijuana, cocaine, crack, ect) (No) (Yes) If yes, when/how often? _____

Do you consume caffeine? (No) (Yes) If yes, how many cups (8oz.) of coffee, soda, tea per day/week? _____

Do you drink alcohol? (No) (Yes) If yes, how many drinks per day/week? _____

Have you ever worked with asbestos or other hazardous materials? (No) (Yes) Explain: _____

Have you engaged in activities which put you at risk of getting AIDS? (No) (Yes) Explain: _____

Do you want to be tested for AIDS and/or other sexually transmitted diseases? (No) (Yes)

Do you wear seatbelts? (No) (Yes) Do you wear a bicycle helmet? (No) (Yes) (N/A)

Are you in a relationship where you have been physically hurt by your partner? (No) (Yes)

Do you ever feel afraid of your partner? (No) (Yes)

Is there a gun in your home? (No) (Yes) If yes, Is it out of the reach of children and unloaded? (No) (Yes)

Have you had a colonoscopy? (No) (Yes) If yes, when was the last procedure? _____

Do you have a "living will"? (No) (Yes) Are you an organ donor? (No) (Yes)

Do you see any other doctors (specialists)? (No) (Yes) Who?_____

_____ _____

DIABETIC PATIENTS:

When was your last eye exam? _____ Who do you see?_____

When was your last foot exam? _____ Who do you see?_____

I have read and understand your 'Notice of Privacy Policy'.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Effective January 1, 2011, a **late fee of $25** will be assessed for co-pays that are 30 days past the due date.

Effective August 1, 2012, a **fee of $20** will be assessed to any appointments that are **missed** or **cancelled** without **24 hours** notice**.**

I consent to treatment by Rhode Island Medicine for my medical conditions.

I give Rhode Island Medicine, Inc. permission to use my protected health information for purposes of treatment, payment and health care operations. I am free to revoke this authorization at any time in writing.

Signature Date