

PATIENT INFORMATION

Full Legal Name Date of Birth Sex at Birth

Social Security # Email Address Preferred Pronouns

Street Address City State ZIP

Home Phone Cell Phone Employer / School

Preferred Contact: Home Cell Email Work

Marital Status: Single Married Divorced Widowed Other

EMERGENCY CONTACT

Emergency Contact Name Relationship Phone

REFERRING PROVIDER

Referring Provider Name Practice / Specialty Phone

PRIMARY INSURANCE

Insurance Company Policy Holder Name Relationship to Patient

Policy Holder DOB Member ID # Group # Plan Type (HMO/PPO/etc.)

SECONDARY INSURANCE (IF APPLICABLE)

Secondary Insurance Company Secondary Policy Holder Name Relationship to Patient

Secondary Member ID # Secondary Group #

CURRENT MEDICATIONS

List all current medications (name, dose, frequency)

KNOWN ALLERGIES

List all allergies (medication, food, environmental) and reactions

PAST MEDICAL CONDITIONS / DIAGNOSES

Past conditions and diagnoses

PAST SURGERIES / PROCEDURES

List surgeries/procedures with approximate dates

FAMILY MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease |

Additional family history notes

REASON FOR TODAY'S VISIT / CHIEF COMPLAINT

Describe your reason for visiting

SOCIAL HISTORY

Tobacco Use: Never Former Current

If former/current — type and amount

Alcohol Use: Never Social Moderate Heavy

Drinks per week (if applicable)

Recreational Drug Use: Never Former Current

Type/detail (if applicable)

Exercise: Sedentary 1-2x/wk 3-4x/wk 5+ x/wk

Diet: Regular Vegetarian Vegan Other

Occupation

Stress Level (1-10)

WOMEN'S HEALTH (COMPLETE IF APPLICABLE)

Age of First Menstrual Period

Date of Last Menstrual Period

Cycle Length (days)

Number of Pregnancies

Number of Live Births

Number of Miscarriages

Number of Abortions

Last Pap Smear Date

Pap Result

Last Mammogram Date

Menopausal Status: Pre-menopausal Peri-menopausal Post-menopausal N/A

Current Contraception: None Oral contraceptive IUD Implant Other

REVIEW OF SYSTEMS — BRIEF

Check all symptoms you have experienced in the past 3 months:

- Fatigue
- Headache
- Chest pain
- Cough
- Diarrhea
- Muscle pain
- Anxiety
- Fever/chills
- Dizziness
- Shortness of breath
- Nausea/vomiting
- Constipation
- Back pain
- Depression
- Weight change
- Vision changes
- Palpitations
- Abdominal pain
- Joint pain
- Skin changes
- Sleep problems

AUTHORIZATION & CONSENT

Authorization for Treatment

I authorize Southern Horizon Healthcare to perform examinations, procedures, or treatments deemed medically necessary by my physician. I understand this does not obligate me to accept any treatment.

Authorization to Release Medical Information

I authorize the release of my medical information as necessary to process insurance claims, obtain prior authorizations, or as otherwise required for treatment purposes.

Financial Responsibility

I understand I am financially responsible for all charges not covered by my insurance. I agree to pay all co-pays, deductibles, and any balances at the time of service.

Photography / Media Consent (Aesthetic Services)

I authorize Southern Horizon Healthcare to take photographs for my medical record and educational purposes. Photos will remain confidential and will not be shared without separate written consent.

PATIENT SIGNATURE

Patient / Guardian Full Name (print)

Date

Relationship to Patient (if guardian)

HIPAA Privacy Notice

Your health information is protected under HIPAA. Our full Notice of Privacy Practices is available at our office and on our website. By signing above you acknowledge receipt of our Notice of Privacy Practices.