Patient History & Information

ELECTRA MEDICAL CLINIC
A Division of
Electra Memorial Hospital

Thomas S. DeLizio, MD Ben Segler, FNP-C Duron Crandord, NP Kelly Warren, NP
(Circle Your Provider)

PLEASE PRINT INFORMATION

Patient Name: _____, _____ Date of Birth: _____
Last Name First Name Middle Initial

Sex: ☐M ☐F Race: _____ Religion: _____ Marital Status: M S D W

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DL #/State: _____ Social Security #: _____-_____-_____

Email Address: _____ Pharmacy: _____

Guarantor Name: _____ Relation to Patient: _____

Employer: _____ Retired? ☐ Y ☐ N If yes, date of retirement: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Medications:

Name of Medication	Reason Prescribed	Dosage	How long on Med

Drug Allergies: _____ Any Other Allergies: _____

Past/Current Medical History (Check all applicable)

☐Lung Disease	☐Cholesterol	☐Asthma	☐Neck Problems	☐Arthritis
☐Liver Disease	☐Heart Disease	☐Hepatitis	☐Sleep Apnea	☐Anemia
☐Kidney disease	☐Chest Pain	☐HIV	☐Thyroid	☐Lupus
☐High Blood Pressure	☐Diabetes	☐Seizures	☐Hyperlipidemia (high concentration of fats or lipids in the blood)	

Past Surgeries, Procedures or Injuries:

Surgery, Procedure or Injury	Reason	Month/Year

Do you use drugs? ☐ Y ☐ N Consume Alcohol? ☐ Y ☐ N Tobacco Use? ☐ Y ☐ N If yes to any of these, how much and how often?

_____

Date of last: Tetanus booster _____ Flu Vaccine _____ Pneumonia Vaccine _____ Shingles Vaccine _____
EKG _____ Colonoscopy or EGD _____ Dexascan _____ Eye Exam _____

Family History (*Please indicate relationship of any family member who has had any of the following*)
Diabetes _____ Cancer _____ HBP _____ Heart Attack _____ Stroke _____

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Insurance Information Form

If insurance policy holder is different than patient, please fill out information below

POLICY HOLDER INFORMATION

Name: _____ Relation to patient: _____

SSN: _____ DOB: _____

INSURANCE INFORMATION

This information needs completed only if copies of insurance card(s) have NOT been provided

Primary Insurance: _____ Name of Insured: _____

ID#: _____ Group #: _____

Relation to Patient: _____ DOB: _____

Other Insurance: _____ Name of Insured: _____

ID#: _____ Group #: _____

Relation to Patient: _____ DOB: _____

ELECTRA
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Electra Hospital District

Patient Responsibilities

To the extent possible, Electra Medical Clinic requests that our patients:

- *Provide accurate and complete information about your past illnesses, hospitalizations, medications and other matters relating to your health, and to answer any questions concerning these matters.*
- *Participate in your health care planning by talking openly and honestly about your concerns with your physician and other health care professionals.*
- *Understand your health problems and treatment to your own satisfaction and to ask questions if you do not understand.*
- *Cooperate with your physician and other health care professionals in carrying out your health care plan.*
- *Inform the clinic staff or any of its professional of the existence of any advance directive (including health care proxy, power of attorney, DNR, living will) you may have created.*
- *Provide information relating to insurance and other sources of payments.*
- *Cooperate and abide by the rules, regulations and policies of the clinic.*

We also ask that you be considerate of your fellow patients, respecting their need for privacy and a quiet environment, as we expect them to do for you as well.

As a patient of Electra Medical Clinic, I agree to be ultimately responsible and pay for any sums due **ELECTRA MEDICAL CLINIC** for services rendered. I understand that I will receive a **SEPARATE BILL** from the Pathologist for pathology specimens and/or the Radiologist for the radiological exams.

Patient _____ Date _____

Responsible Party _____ Relationship _____