Capstone Family Practice

Patient Name _____ Date of Birth_____

Address _____ Zip Code_____

Primary phone (cell / home) _____ Secondary phone (cell / home) _____

Email Address_____

Emergency Contact: Name_____Phone_____Relationship_____

Preferred Pharmacy_____ Phone_____

I wish for my test results and medical information to be released to:

_____Myself only

_____Myself and _____

Please Circle One: I DO / I DO NOT authorize results to be left on my voicemail

Preferred phone number for lab results: _____

Consent to Treat Unaccompanied Minor

Please Circle One: I DO / I DO NOT authorize and give consent for my child, listed above, to go independently to appointments and consent to all medical and/or surgical treatment without the presence of a parent or legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.

Signature of Understanding:

I have read and understand the attached stated office and financial policy.

Patient Signature_____ Date: _____

Parent/Guardian Name (Print)_____Relationship: _____

Parent/Guardian Signature _____Date: _____

Preventive Health Update

Have you ever had a blood transfusion? □ Yes □ No

When was your last dilated eye exam? _____ Glaucoma screening? _____

For Men: Have you ever had your prostate checked? Yes ____ No____ Date: _____

For Women: When was your last pap smear? _____ Results: _____

Mammogram? _____ Results: _____

If you are over 50: Have you had a:

Screening colonoscopy? Yes ____ No____ Date: _____Results: _____

Bone density scan? Yes ____ No____ Date: _____ Results: _____

EKG? Yes ___ No____ Pneumonia shot? Yes ___ No___ Shingles vaccine? Yes ___ No____