

PROGRESSIVE PHYSICIAN ASSOCIATES, INC.**MEDICAL HISTORY**

Do you currently have or have you had any of the conditions listed below? **Please circle yes or no.**

General

Height: _____ Weight: _____

Do you smoke? Yes No

How Much? _____

How Long? _____

Quit? Year _____ Yes No

Alcohol? Yes No

Diabetes Yes No

High Cholesterol Yes No

Weight Loss Yes No

Fatigue Yes No

Loss of Appetite Yes No

Cancer Yes No

Area of Body _____

Eyes

Glasses Yes No

Blurred Vision Yes No

Blindness Yes No

Double Vision Yes No

Ears

Hearing Loss Yes No

Vertigo Yes No

Neck

Hoarseness Yes No

Swallowing Difficulty Yes No

Lumps Yes No

Chest

Shortness of Breath Yes No

Cough Yes No

Asthma Yes No

Sputum Production Yes No

Emphysema Yes No

COPD (Pulmonary Disease) Yes No

Cardiovascular

Chest Pain Yes No

Hypertension Yes No

Heart Failure Yes No

Pulmonary Edema Yes No

Irregular Heart Beat Yes No

Palpitations Yes No

Heart Attack Yes No

Pacemaker Yes No

Heart Surgery/Bypass Yes No

Heart Angioplasty Yes No

Heart Valve Replacement Yes No

Gastrointestinal

Nausea/Vomiting Yes No

Diarrhea Yes No

Blood in Stool Yes No

Constipation Yes No

Kidneys

Failure Yes No

Updated _____

**PROGRESSIVE PHYSICIAN ASSOCIATES, INC.
PATIENT INFORMATION**

Date: _____

Name: First _____ MI _____ Last _____ Sex M / F

Birthdate _____ Age _____ Social Security _____ - _____ - _____

Address _____

City _____ State _____ Zip Code _____

Telephone (____) _____ E-Mail Address _____

Occupation _____ Retired: Yes / No

Employer _____ Telephone (____) _____

Employer Address _____

Marital Status: S M W D Spouse's Name _____ Work Telephone (____) _____

Person to Contact in Emergency other than spouse _____

Relationship _____ Telephone (____) _____

Referring Doctor _____ **Telephone (____)** _____

Family Doctor _____ **Telephone (____)** _____

Cardiologist _____ **Telephone (____)** _____

Nephrologist _____ **Telephone (____)** _____

Dialysis Center _____ **Telephone (____)** _____

Dialysis Days and Time _____

Pharmacy Name _____ **Telephone (____)** _____

Please list all past surgeries and dates:

Please list all medications and dosages you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PLEASE MARK APPROPRIATE SECTION AND SIGN BELOW
PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURANCE CARDS FOR
PHOTOCOPYING.**

Guarantor of Insurance

Medicare

_____ I request that payment of authorized Medicare benefits be made on my behalf to Progressive Physician Associates, Inc. for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care financing administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, co-insurance and non-covered services.

Managed Care/Commercial Insurance

_____ I authorize the processing of medical insurance either by electronic or manual method by Progressive Physician Associates, Inc. My signature authorizes payment of all major medical and/or surgical benefits to which I am entitled from the listed insurer to pay to the provider assignee. I authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

Medigap

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_____ I request that payment of authorized Medigap benefits be made on my behalf to Progressive Physician Associates, Inc. for any services furnished me by the listed physician/supplier. I authorize any holder of medical information needed to determine these benefits payable for related services. This

assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Tricare/Champus/Champva

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_____ I request that payment of authorized benefits to me or on my behalf for any services furnished me by Progressive Physician Associates, Inc. including physician services. I authorize any holder of medical or other information about me to release to TSO/CHAMPUS and its agents any information needed to determine these benefits or benefits related services. Professional providers must include the name of the provider that maintains the signature on file.

Patients Name _____

Please Print

Signature _____

Updated: 5/14/2004