Advanced Medical Care
Home Visits

Patient Information

Name:_____

Address: _____

_____

Phone: _____ Email:_____

Social Security Number:_____ Gender: (circle one) M F

Date of Birth:_____

Medicare Number (include suffix):_____

DSHS Patient Identification Code (PIC):_____

Secondary Insurance or Private Pay:_____

If private pay, please fill out the Additional Contact Information, below. This will be the responsible party for billing purposes.

Preferred Pharmacy:_____

Is the patient Full Code (Resuscitate) or No Code (Do Not Resuscitate)? (Circle One)
Please include copies of the patient's Medicare card and any other insurance cards

Additional Contact / Responsible Party / Emergency Contact Information

Name:_____Relationship:_____

Address:_____

City:_____State:_____Zip:_____

Phone: (___)_____ Email: _____

Does this person have medical **Power of Attorney**? (Circle One): Yes No

Is this person the **financially responsibly party**? (Circle One): Yes No

Financial Responsibility Agreement to Pay

I accept full financial responsibility for services rendered by Advanced Medical Care providers. Should my insurance company deny a visit or pay for a portion of a visit, I understand that I will be required to pay for these services in full.

Patient / Representative Signature:_____Date:_____

Medical history

Current Concerns:

IMMUNIZATIONS	**YES**	**NO**	**UNKNOWN**	**DATE**	**REFUSES**
COVID					
INFLUENZA					
PNEUMONIA					
TETANUS					
SHINGLES					

Medical History
Check all that apply, and fill out the lower portion if necessary.

Condition	Now	Past	Condition	Now	Past
Allergies			Hemorrhoids		
Alzheimer's Disease			High Blood Pressure		
Anemia			Kidney Problems		
Anxiety			Leg Swelling		
Arthritis			Liver Problems		
Asthma			Migraines		
Bladder Problems			Pain (_____)		
Incontinence			Prostate Problems		
Urinary Tract Infection			Skin Disease		
Blood Clots			Stomach Problems		
Blood Vessel Problems			Nausea		
Bowel Problems			Stomach Ulcer		
Constipation			Vomiting		
Cramps			Stroke		

Diarrhea			Thyroid Disease		
Irritable Bowel Synd.			Trouble Sleeping		
Rectal Bleeding			Tuberculosis		
Breast Problems			Ulcer (_____)		
Bronchitis			Reproductive Problems		
Cancer (_____)			Abnormal Pap Smear		
Dementia			Hysterectomy		
Depression			Sterility, Genetic		
Diabetes (Type 1 or 2)			Sterility, Optional		
Emphysema			Vaginal Bleeding		
Epilepsy/Seizures			Vision Problems		
Fatigue or Tiredness			Cataracts		
Fractures:_____			Glaucoma		
Gall Bladder Problems			Weight Gain		
Hearing Problems			Weight Loss		
Heart Problems			Other:		

SOCIAL HISTORY:
Smoking: Do you currently smoke? ____ If so, how many packs per day?
Smoking: Did you smoke in the past? ____ When did you quit?
Alcohol use: How many drinks per day? ____ per week? _____
Medical Marijuana/History of other recreational drugs
Marital Status
Level of School and Previous Occupation
Caffeine use: how often?
Children

SURGICAL HISTORY: please provide any information - dates, type, effects, etc.

Recent Hospitalization (please describe, with dates):

In the past MONTH, have you had any of the following problems?

__Recent weight gain or loss; how much____ ___Change in appetite
__Depression __ Anxiety ___Agitation/Aggression ___Memory Loss __Suicidal thoughts
__Headaches __ Dizziness ___Fainting or loss of consciousness ___Numbness/tingling
__Vomiting ___Stomach pain __Heartburn
__Muscle weakness/Falls ___Frequent sore throats ___Difficulty swallowing ___Jaw pain

ALLERGIES: _____

_____

MEDICATIONS (list all current): _____

_____

_____

_____

FAMILY HISTORY

	Present age if living	Age at death	Cause of death
Father			
Mother			
Siblings			
Children			
Spouse			

Do you use any of the following?

__Walker

__Wheelchair

__Hospital Bed

__Oxygen

__CPAP/BiPAP

__Glucometer

__Other

Please note OTHER PROVIDERS, WITH OFFICE NAME:

__PCP

__CARDIOLOGY

__PULMONOLOGY

__NEUROLOGY

__GERONTOLOGY

__NEPHROLOGY

__HEMATOLOGY-ONCOLOGY

__PSYCHOLOGY/COUNSELING

__HOMECARE AGENCY

__PERSONAL CAREGIVER

__OTHER