SPARKS&FAVOR, P.C.

Name				Social Security Number
Address		City		State Zip
Home Phone Number	Cell Phone Number	Work Phone Number		Pharmacy Name
Birth date	Marital Status (circle) M S D W	Email Address		Pharmacy Phone Number
Place of Employment			Occupation	
Spouse/Partner's Name		Birth date	Occupation	
Place of Employment		Primary Phone Number Home ☐ Cell ☐		Work Phone
Referring Doctor/Primary Physician		Where did you hear about Sparks & Favor?		

INSURANCE INFORMATION

Insurance Company		Contract/Policy Number
Name of Employer		Group Number
Name of Policy Holder	Date of Birth	Relationship
Address	City	State Zip
Insurance Company		Contract/Policy Number
Name of Employer		Group Number
Name of Policy Holder	Date of Birth	Relationship
Address	City	State Zip

In Case of Emergency Please Notify:

Name		Relationship
Address	City	State Zip
Primary Phone Number Home ☐ Cell ☐	Work Phone Number	

MEDICARE ASSIGNMENT

Statement to permit payment of medical benefits to physicians.

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request the payment of authorized benefits be made on my behalf. I assign benefits payable for physicians service or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Patient or Responsible Party ____ Date________________

ALL OTHER INSURANCE

I hereby authorize Sparks & Favor, PC to release any information acquired in my examination or treatment to any insurer, government agency providing benefits, or to anyone for charges. I hereby assign and authorize payment directly to Sparks & Favor, PC of all benefits payable under the terms of any insurance policy listed above. I realize the insurance, and/or liability claims may not pay all of the bill. I agree to pay the difference or the entire bill if necessary. I also agree to pay costs of collection, including Attorney's fee and waive my exemption under the constitution and laws of the State of Alabama.

Patient or Responsible Party ____ Date________________

PATIENT NAME ______________________________

Why are you here to see the doctor today?

- ☐ Annual
- ☐ Problem(s): 1) ______________________________
  2) ______________________________

Date of last Pap Smear: ______________ ☐ Normal ☐ Abnormal ☐ N/A

Date of last Mammogram: ______________ ☐ Normal ☐ Abnormal ☐ N/A

Date of last Colonoscopy: ______________ ☐ Normal ☐ Abnormal ☐ N/A

Current Medications: ______________________________

____

Allergies: ______________________________

Illness(es):

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Thyroid Dysfunction
- ☐ Asthma
- ☐ Cancer
- ☐ Thrombosis or Pulmonary Embolism
- ☐ Sleep Apnea
- ☐ Other Illness: ______________________________

Surgeries (Procedure/Date):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Tobacco Use: ☐ No ☐ Yes _______Packs per day

Alcohol Use: ☐ No ☐ Yes _______Drinks per day

Family History:

Mother ☐ Living ☐ Deceased - Cause: ______________________________

Father ☐ Living ☐ Deceased - Cause: ______________________________

Sibling: _____ Number Living _____ Number Deceased - Cause: ______________________________

- ☐ Diabetes ______________________
- ☐ Heart Disease ______________________
- ☐ High Blood Pressure ______________________
- ☐ Osteoporosis ______________________
- ☐ Colon Cancer ______________________
- ☐ Breast Cancer ______________________
- ☐ Ovarian Cancer ______________________
- ☐ Other Cancer ______________________

Obstetrical History:

Total Pregnancies	Full Term Pregnancies	Premature Pregnancies	Abortions	Miscarriages	Tubal Pregnancies	Twins (sets)	# of Living Children

Pregnancy Details *(complete if you are pregnant or planning future pregnancies):*

Date	Gestational Age (wks)	Labor Hours	Weight	Sex	Type Delivery	Anesthesia	Place of Delivery	Complications/Comments/Name

Menstrual History:

Date Last Period Started:__________ How many days do you bleed each cycle?__________

Are you having any problems with your menstrual cycle? ☐ No ☐ Yes

Describe your menses: ☐ Regular ☐ Irregular ☐ Heavy ☐ Painful ☐ Clots

How long is your menstrual cycle? ______ days (1st day of one period to 1st day of next period)

Contraception (at the present time): ☐ None ☐ Hysterectomy ☐ Tubal Ligation ☐ Vasectomy
☐ Birth Control Pill ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Rhythm

Have you noticed recent problems related to the following:

General Health? ☐ No problems ☐ Yes – ☐ Wt. Gain ☐ Wt. Loss ☐ Fever ☐ Fatigue
☐ Other:__________

Eyes? ☐ No problems ☐ Yes – ☐ Vision Change ☐ Glaucoma
☐ Other:__________

Ear/Nose/Throat? ☐ No problems ☐ Yes – ☐ Ulcers ☐ Sinusitis ☐ Ringing in Ears
☐ Other:__________

Heart? ☐ No problems ☐ Yes – ☐ Chest Pain ☐ Shortness of Breath ☐ Irregular Heart Beat
☐ Other:__________

Lungs? ☐ No problems ☐ Yes – ☐ Wheezing ☐ Cough ☐ Coughing Up Blood
☐ Other:__________

Stomach/Colon? ☐ No problems ☐ Yes – ☐ Diarrhea ☐ Blood in Stool ☐ Nausea ☐ Constipation
☐ Other:__________

Kidney/Bladder? ☐ No problems ☐ Yes – ☐ Blood in Urine ☐ Dysuria ☐ Urgency ☐ Frequency ☐ Incontinence
☐ Other:__________

Muscles/Bones/Joints? ☐ No problems ☐ Yes – ☐ Muscle Weakness ☐ Joint Pain ☐ Muscle Pain
☐ Other:__________

Nervous System? ☐ No problems ☐ Yes – ☐ Fainting Spells ☐ Seizures ☐ Numbness ☐ Memory Loss
☐ Other:__________

State of Mind? ☐ No problems ☐ Yes – ☐ Depression ☐ Crying ☐ Anxiety
☐ Other:__________

Endocrine System? ☐ No problems ☐ Yes – ☐ Diabetes ☐ Thyroid Disorder ☐ Heat/Cold Intolerance
☐ Other:__________

Blood & Lymph Nodes? ☐ No problems ☐ Yes – ☐ Easy Bruising ☐ Free Bleeder ☐ Enlarged Lymph Nodes ☐ Transfusions
☐ Other:__________

Skin? ☐ No problems ☐ Yes – ☐ Rash ☐ Ulcers ☐ Moles (Enlarging/Changing)
☐ Other:__________

Breasts? ☐ No problems ☐ Yes – ☐ Pain in Breast ☐ Nipple Discharge ☐ Breast Nodule
☐ Other:__________

Patient Signature__________ Date__________

PLEASE COMPLETE IF YOU ARE PREGNANT OR PLANNING A PREGNANCY.

Please help us evaluate potential genetic risks for you pregnancy by answering the follwoing questions. Please check the 'Yes' or 'No' answer. Please provide the details of any positive in the space at the bottom of this page.

Have you, the baby's father or anyone in either family ever had:

Down's Syndrome___	☐ Yes	☐ No
Other Chromosome Abnormality___	☐ Yes	☐ No
Neural Tube Defect, such as Open Spine___	☐ Yes	☐ No
Any Other "Birth Defects"___	☐ Yes	☐ No
Cystic Fibrosis___	☐ Yes	☐ No
Muscular Dystrophy___	☐ Yes	☐ No
Sickle Cell Disease___	☐ Yes	☐ No
Hemophilia___	☐ Yes	☐ No
Mental Retardation___	☐ Yes	☐ No
Tay Sachs Disease___	☐ Yes	☐ No
Multiple Miscarriages___	☐ Yes	☐ No
Diabetes___	☐ Yes	☐ No
Thallasemia (Inherited Anemia)___	☐ Yes	☐ No

If you or your spouse is:	Have you been tested for:			Results:
_____ Black	Sickle Cell	☐ Yes	☐ No	___
_____ Italian, Greek	B-Thallasemia	☐ Yes	☐ No	___
_____ Mediterranean	Tay Sachs	☐ Yes	☐ No	___
_____ Southeast Asian				
_____ Jewish				

Besides vitamins, have you taken any medication since your last period?___

If yes, please list medication:___

Have you ever used "recreational" drugs?	☐ Yes	☐ No
Have you ever had herpes, gonorrhea, or syphilis?	☐ Yes	☐ No
Chlamydia, genital warts, or any sexually transmitted disease?	☐ Yes	☐ No

Details:___

___

___

___ ___/___/___ ___

Your Name (Please Print) Date Your Signature

Patient Contact Information

Patient Name: ____

Social Security Number: ____

Any physician, staff, employee, or representative of Sparks & Favor PC has my permission to discuss my account and medical conditions—which may include symptom, treatments, diagnosis, test results, medications or any other type of protected health information—with the following persons in order to facilitate and coordinate my care, treatment, and payment.

☐ Check here if you choose NOT to allow access of your medical records to anyone.

______________________	______________________	______________________
(name)	(relationship)	(phone)
______________________	______________________	______________________
(name)	(relationship)	(phone)
______________________	______________________	______________________
(name)	(relationship)	(phone)
______________________	______________________	______________________
(name)	(relationship)	(phone)
______________________	______________________	______________________
(name)	(relationship)	(phone)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can withdraw this permission by signing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if this information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

____ ______________________

(Patient's Signature) (Date)

Note Regarding Annual Exams

A yearly exam without a co-pay does not apply to visits addressing problems or complaints (such as abnormal bleeding, menopausal symptoms, breast pain, etc.). For our patients' convenience, our physicians are very pleased to address any concern or problem you may have at the same time as your yearly exam. Please be aware, however, that an office visit will be submitted to your insurance company and a co-pay may be required.