SPARKS & FAVOR, P.C.

Name			SSN
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

SPARKS & FAVOR, P.C.

Patient Contact Information

Patient Name: _____

Date of Birth: _____

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.