Welcome to The Country Doctor, Ltd. Please complete this Patient Chart Initial Demographics Form

Prefix | Last name | First Name | Middle Name | Suffix | Date of Birth

Home Phone | Social Security # | Gender | Marrital status

Home Address | Home City | State | Home Zip

Cell Phone

Work name | Occupation | Work Phone

Primary Insurance | Primary Insurance Policy Number 2 OR ID# | Group # | Insurance Phone Number

Secondary Insurance | Secondary Insurance Policy Number 2 OR ID# | Group # | Insurance Phone Number

Reason for visit today Flu shot only; not establishing care

MEDICATION OR SUBSTANCE ALLERGIES

These illnesses or items apply to me

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Diabetes | ☐ Joint replacement | ☐ Substance abuse |
| ☐ Anxiety | ☐ Eating Disorder | ☐ Kidney disease | ☐ Thyroid illness |
| ☐ Arthritis | ☐ Gastritis | ☐ Liver disease | ☐ Tobacco use |
| ☐ Artificial heart valve | ☐ Heart Attack | ☐ Mitral Regurgitation | ☐ Tuberculosis |
| ☐ Asthma | ☐ Heart failure | ☐ Pacemaker | ☐ Ulcers |
| ☐ Autoimmune illness | ☐ Heart Murmur | ☐ Pneumonia | ☐ Other illnesses (list) |
| ☐ Bronchitis | ☐ Heart surgery | ☐ Psychiatric treatment | |
| ☐ Cancer (including treated) | ☐ Heart valve replacement | ☐ Seizures | |
| ☐ Chest pain or angina | ☐ Hepatitis | ☐ Sickle Cell Anemia | |
| ☐ Cough | ☐ Hernia | ☐ Spleen Removed | |
| ☐ Depression | ☐ High blood pressure | ☐ Stroke or TIA | |

Immunizations are up to date ☐ yes ☐ no

I consent to have The Country Doctor give a vaccine to myself, or the person named on this form, if I am that person's legal guardian. I consent to have my insurance, HMO, PPO, Medicare, etc., billed for my care at The Country Doctor, Ltd, and I consent to release medical information to process claims concerning the person listed on this form. Please note that insurances require patients to pay for vacccines, a copay, a percentage of the visit, and/or a deductible. You are responsible for these fees and deductibles. I understand that it is my responsibility to check with my health coverage plan regarding the coverage of any immunizations. I have reviewed the payment policies, and I will pay the required fees.

Signature of patient, parent, or guardian | Date | Printed name of person who signs the form and relationship to patient