Patient Demographic Form

Patient Information

First Name: ______________________ Middle Initial: _____________ Last Name: __________________
Date of Birth: ____________________ Social Security Number: ______________________________
Marital Status (please circle): Single Married Other ________ Sex at Birth (please circle one): F or M
Mailing Address: ________________________________ City, State, Zip Code: _________________
Phone Number (H) _____________________ Cell _________________ Work __________________
May we leave a message regarding appointments and labs? Home Y or N/ Cell Y or N/ Work Y or N
Whom may we leave a message with? ____
Email Address: ____
Preferred Language: ____
Pharmacy: __________________________ Address: ______________________________________

Please circle what applies to you:

Race: White/ African-American / Asian / Other
Ethnicity: Hispanic / Non-Hispanic
Veteran: Yes, or NO
Hearing: HOH or Deaf-Hearing Aide
Vision Impaired: Blurred Vision / Legally Blind / Blind
Please circle what applies to you: Homeless / Seasonal Worker / Migrant / Lives with others
Birth Order: 1st born / 2ndborn / 3rdborn other_________
Do you: OWN / RENT / LIVE IN PUBLIC HOUSING
Federal Mandated Questions:
Sexual Orientation: Lesbian/Gay /Straight /Bisexual/ Something Else /Don't Know /Not Disclosing
Gender Identity: Male/Female/Transgender Male-Female to Male/ Transgender Female-Male to Female

LEGAL GUARDIAN – MUST BE COMPLETED IF PATIENT IS UNDER THE OF AGE OF 18

Foster Child: Yes, or NO
Father's Name: ____
Social Security Name: _____________________________________ Date of Birth: _______________
Mailing Address: ________________________________ Phone Number: ______________________
Mother's Name: ____ Date of Birth: ______________
Social Security Number: __________________________ Phone Number: ______________________

PAYMENT GUARANTEE – MUST BE SIGNED!

I, ______________________________, hereby verify that all information provided by me is true and correct to the best of my knowledge. I authorize Williamson Health Wellness Center to make any investigation necessary to verify my eligibility for financial assistance or insurance coverage with my account. If the insurance or financial assistance information provided by me is false, I agree to pay for all services rendered (the sliding fee scale discount will be reverse to the appropriate pay status). I consent to any services rendered to me or my dependents by the attending provider/physician. I agree to pay all fees and charges for such treatment promptly upon presentation of charges, unless credit arrangements are in writing within thirty days of billing date. I hereby authorize that my insurance benefits be paid directly to Williamson Health Wellness Center. I realize that I am responsible to pay for all non-covered services. I also authorize the release of any pertinent medical information to insurance carriers necessary to process payment for professional services rendered by Williamson Health Wellness Center.

Patient/Parent/Legal Guardian Signature: ______________________ Date: __________
Staff Witness Signature: ______________________________ Date: __________

HOW WERE YOU REEFERRED TO US?

By your employer	Family/Friends	Insurance Company	Website/other
Hospital	Radio	Advertisement	Facebook

CONSENT FOR MINOR CHILDREN

I, ______________________________, (parent/legal guardian) of ______________________________ (child's name) give consent for the following person(s) to seek treatment when I cannot accompany my child to Williamson Health Wellness Center

(Person's Name) ______________________________
(Person's Name) ______________________________
(Person's Name) ______________________________
(Person's Name) ______________________________

To Accompany the Child

________ I give permission for this person to seek medical, dental or behavioral health
(initial) treatment (including any type of procedure, surgery) and provide consent for such Treatment without having to contact me.

________ This form will remain in effect until revoked
(initial)

Parent or Legal Guardian Signature: ______________________ ***Date:*** __________

Protecting Your Private Health Information and Risks:

This method of communication and viewing prevents unauthorized parties from being able to access or read messages secure transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:

1. The secure message must reach the correct email address, and
2. Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. ***It is important our practice has your correct email address and that you inform us of any changes to your email address.***

You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.

Patient Acknowledgement and Agreement:

I acknowledge that I have read and fully understand this consent form and Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: ____
Print Name: ______________________________ D.O.B: ________________
Patient Signature: ___________________________ Date: ________________

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients aged 13-18 years.

Name of Parent/Guardian Requesting Access: ______________________________
Relationship to Patient: ___________________________ Date: ______________

Our Patient Portal site may be accessed by two different URL's.
Our Website: www.williamsonhealthwellness.com
Patient Portal direct site: https://mycw91.ecloud.com/portal12158/isp/100mp/login.isp

ADULT HEALTH QUESTIONNAIRE

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss with your doctor. Please fill out as much of this questionnaire as possible. If you cannot answer some of the questions or feel uncomfortable answering them, leave then blank. Thank you for your help!

Date: ______________

PATIENT NAME: ______________________________________ D.O. B: ______________________

What would you like to talk to your doctor about today? ____________________________________

MEDICAL HISTORY

PLEASE LIST ANY MEIDCATION ALLERGIES OR REACTIONS:

____

PLEASE CIRCLE TO INDICATE IF YOU HAVE EVER HAD THE FOLLOWING CONDITIONS:

Diabetes	High Blood Pressure	Asthma
Kidney Disease	Hepatitis	Thyroid Disease
Stroke	Depression	Emphysema
Tuberculosis	Coronary Artery Disease	Heart Attack
Arrhythmia	Seizures	Congestive Heart Failure

Sexual Transmitted Disease – Type: ____

Eye Problems – Type: ____

Cancer – Type: ____

Other, Please Explain: ____

Please list any surgeries or hospital stays you have had and their approximate date/year:

Type of Surgery/Reason for Hospitalization	Location/Date of Service
_________________________________	______________________________
_________________________________	______________________________
_________________________________	______________________________

If you have any other medical problems or serious injuries that are not listed above, please describe:

____

When was your last Physical? ____

Patients Name: ____ **D.O.B:** ___________

FAMILY HISTORY

Please check any disease that runs in your family and please note who had it:

- Alcoholism or Drug Use ______________________________________
- Cancer ______________________________________
- Cancer Type ______________________________________
- Diabetes ______________________________________
- Heart Disease ______________________________________
- High Blood Pressure ______________________________________
- High Cholesterol ______________________________________
- Osteoporosis ______________________________________
- Mental Illness ______________________________________
- Stroke ______________________________________
- Thyroid Disease ______________________________________
- Other ______________________________________

Other Comments:

____
____
____
____

HEALTH HABITS

Do you smoke or use tobacco products? _____ YES _____NO ___QUIT

- Number of cigarettes each day? _______________
- For how many years? _______________
- Other forms of tobacco used? _______________

Do you drink alcohol? ___ YES ___NO ___Quit

- How much? ___________
- How often? ___________

Have you ever felt that you should cut down on your drinking? ___YES ___NO

Have you regularly used other drugs? ___YES ___NO

- If yes, are you still using them? ___YES ___NO