Putnam Family Care, Inc

6101 Crill Avenue
Palatka, FL 32177
(386) 326-1225

Personal Information

Last Name_____ First _____ Middle_____
Mailing Address_____ Home Phone (___)_____
City_____State_____Zip_____Cell Phone (___)_____
Social Security #_____Date of Birth_____Age____Sex_____
Email Address: _____

How did you find out about us? __word-of-mouth __drive-by __Google
__Yahoo __Bing __Facebook __my employer
__phonebook __print ad(where?_____) __other(what?_____)

Ethnicity: __ Hispanic __non Hispanic or Latin
Race: __African American __White __Hispanic __Other
Pharmacy (include City): _____

Employer Information **Spouse or Significant-Other Information**

Patients Occupation: _____ Name: _____
Patients Employer: _____ Address: _____
Employer Address: _____ Phone:(__)_____ S.S.#_____
_____ Occupation: _____
Employers Phone: _____ Phone: (__)_____

Policy Holder Information

Responsible Party _____S.S.#_____
Address_____ Date of Birth_____
City_____ State_____ Zip _____
Phone (___)_____Relationship to Patient _____
Occupation _____Employer _____
Work Phone (___)_____Work Address _____

Emergency Contact Information
Name _____ Relationship to Patient _____
Home Phone (___)_____ Cell Phone (___)_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures; they sometimes refer to as "Reasonable and Customary Fees". We do not accept this as payment in full (unless otherwise restricted by law or agreement we may have with your insurer). Also some of the insurance companies only pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance or any other balance not paid by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE DO REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE INITIATION OF EACH VISIT. In the event the account is turned over for collection, the collection fees and/or legal fees, including attorney fees, shall be your responsibility.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurances and other health plans to the facility listed in the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure this payment, via fax Transmittal or hard copy.

Signature_____ Date _____

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Drug Allergies:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Surgeries: (circle)

Appendix	Hernia	Gallbladder	Prostate
Hysterectomy	Heart bypass	Thyroid	Sinus
Tubes tied	Heart valve	Stomach	Kidney
Ovary 1 or 2	Pacemaker	Colon	Pancreas
Lung	Brain	Spleen	Eye
Breast	Tonsils	Skin	Joints
Back	Neck		

List other:
_____
_____
_____
_____
_____
_____

Medical Problems: (circle)

Blood pressure	Cholesterol	Diabetes	Asthma
Stroke	Seizure	Reflux	COPD
Heart	Thyroid	Arthritis	Gout
Allergies	Skin disease	Glaucoma	HIV
Prostate	Bladder	Kidney	Pancreas
Hepatitis	Liver	Ovary	Breast
Bleeding disease	Stomach ulcer	Gastritis	Osteoporosis
Kidney stone	Gallstone	Cancers	

List other:
_____
_____
_____
_____
_____
_____
_____

Family History: (circle)

Diabetes	Asthma or lung
High blood pressure	Stroke
Arthritis	Heart
Cancer	Kidney

List other:
_____
_____
_____
_____

Prescriptions:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Alcohol (drinks per week)_____
Smoke: (packs per day)_____
Drugs (not prescribed by a doctor): No__ Yes_____
Immunizations (date of last):

- Tetanus _____