Peachtree PRIMARY CARE, PC

1570 Old Alabama Road, Suite 105, Roswell, GA 30076
Telephone: 770-676-6838 - Fax: 770-676-6840

Patient Information

Last:	First:	Middle:
Social Security Number:	Birthdate:	Gender: M / F

Primary Billing Address			Pharmacy Information	
Street:		Apt #	Pharmacy Name & City:	
City:	State:	Zip:	Address or Cross Streets:	Tel Number:

Contact Information	Emergency Contact Information
Home Phone:	Name:
Mobile Phone:	Relationship:
Daytime/Work Phone:	Home Number:
Email-*required* :	Mobile Number:

Marital Status (Circle one): Single Married Divorced Separated Widowed Other

Occupation:	Employer:	Status: Full Time / Part Time

Insurance Information (fill out completely)

Primary Insurance	Secondary Insurance (if applicable)
Insurance Company:	Insurance Company:
Member ID:	Member ID:
Group Number:	Group Number:

Responsible Party Information (if different than above)

Last:	First:	Middle:	
Street:	Apt #	Social Security Number:	
City:	State: Zip:	Birthdate:	Gender: M / F

Last:_____ First:_____ Birthdate:_____

Medical Information

History of Presenting Illness…*why are you here today? Describe your main problem*

Where?	How Long?

How Severe? *Mild* 1 2 3 4 *Moderate* 5 6 7 8 9 *Severe* 10

Have you seen a doctor for this condition? Y / N	If so, please provide doctors name & number…

Allergies…*tell us about any food and drug allergies*

Ingredient /Allergen / Brand (i.e. aspirin)	Describe the Reaction (i.e.. Nausea)
1._____	1._____
2._____	2._____
3._____	3._____

Current Medications…*please list all (including non-prescription)*

Medication Name	Strength	Dosage
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____

Social History

Tobacco Use?	Yes	No	Former	Alcohol Use?	Yes	No	Former
Illicit Drug Use?	Yes	No	Former	Caffeine Use?	Yes	No	Former

Past Medical History

Please check all conditions that apply…

Alcoholism		Cardiac Disease		Abnormal Heart Beat		MRSA / VRE	
Allergies		CVA		Hepatitis A, B or C		Heart Attack	
Anemia		COPD / Emphysema		HIV / AIDS		Osteoporosis	
Angina		Coronary Artery		Hyperlipidemia		Peptic Ulcer	
Arthritis		Dementia		Hyper/Hypothyroidism		Pulmonary Fibrosis	
Asthma		Depression		Inflamm. Bowel		Radiation	
Blood Disorders		Diabetes		IBS		Seizures	
Blood Clot / DVT		Diverticulitis		Kidney Disorder		Sleep Apnea	
Blood Transfusion		Endocarditis		Liver Disease		Stroke	
Cancer		Gallbladder Disease		Lung Disease		Thyroid Disease	
Cardiac Arrest		GERD / Acid Reflux		Lupus		Tuberculosis	
Cardiac Dysrhythmias		Heart Disease		Migraine Headaches		Ulcerative Colitis	

Other:

Past Hospitalization, Illness and Surgical History…*include ALL major medical procedures or testing*

Date	**Description of illness or procedure**
1._____	1._____
2._____	2._____

Family History

Please list all immediate family members that have been diagnosed with any medical conditions (diabetes, high blood pressure, etc.)

Relationship	**Age**	**Deceased**		**Illness or Disease**
1._____	_____	Yes	No	1._____
2._____	_____	Yes	No	2._____
3._____	_____	Yes	No	3._____

Do you have children? Y / N If Yes, please list their ages_____

Print Name: _____ Date:_____

Patient Signature:_____