Journey Medical
Let food be thy medicine
207 Chartwell Court • Myrtle Beach, South Carolina 29588 • (843)222-0391 • https://journeymedical.org

# NEW PATIENT INFORMATION

## PATIENT INFORMATION

**Patient Name:** _____ **Date of Birth:** _____ **Today's Date:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip Code:** _____

**Phone:** _____ **Mobile:** _____

**Marital Status:** o Single o Married o Widowed o Divorced o Separated o Domestic Partner

**Any Children?:** o Yes o No

**Primary Care Physician:** _____ **Pharmacy:** _____

**Pharmacy Phone:** _____

## PATIENT EMPLOYMENT INFORMATION

**o Employed o Self Employed o Unemployed o Disabled o Retired**

**Occupation:** _____

**Employer's Address:** _____

**Employer's Phone:** _____

**Who may we thank for referring you to our office?** _____

**In case of an emergency who should be notified?** _____

## PATIENT MEDICAL INFORMATION

**Do you have any of the following symptoms?**

- o Chest Pain / Tightness / Pressure
- o Palpitations
- o Irregular Heart Beat
- o Poor Circulation (Claudication)
- o Lack of Energy / Easy Fatigue
- o Shortness of Breath
- o Lightheadedness / Dizziness
- o Substantial Weight Gain or Loss
- o Fainting / Near Fainting
- o Swelling of Feet and / or legs

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**Other Complaints:**

_____

_____

_____

_____

| FOR OFFICE STAFF USE ONLY |
| --- |
| Comments:<br>_____<br>_____<br>_____<br>_____<br>ROS:<br>_____<br>_____<br>_____<br>_____ |

## HEART RELATED PROBLEMS

**Have you had or been diagnosed with any of the following conditions?**

- o Heart Attack
- o Angioplasty / Stent
- o Bypass Surgery
- o Congestive Heart Failure
- o Syncope (fainting / loss of consciousness)
- o Pacemaker
- o Defibrillator
- o Mitral Valve Prolapse
- o Other Heart Valve Problems
- o Heart Rhythm Problems
- o Atrial Fibrillation
- o Ventricular Fibrillation / Tachycardia

## OTHER MEDICAL PROBLEMS

**Have you had or been diagnosed with any of the following other conditions?**

- o AIDS / HIV
- o Anemia
- o Arthritis
- o Epilepsy / Seizures
- o Glaucoma
- o Hepatitis
- o Psychiatric Problem
- o Depression
- o Bipolar Disorder

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- o Asthma
- o Bleeding Disorders
- o Cancer
- o Cataracts
- o Diabetes
  - o Insulin Dependent
  - o Non-insulin Dependent
- o Emphysema / COPD
- o High Cholesterol
- o High Blood Pressure
- o Kidney Failure / Kidney Stones
- o Liver Failure
- o Migraine Headaches
- o Multiple Sclerosis
- o Pneumonia
- o Prostate Problem
- o Schizophrenia
- o Suicide Attempt
- o Rheumatic Fever
- o Sexually Transmitted Disease
- o GERD
- o Stroke / Mini-Stroke (TIA)
- o Thyroid Problems
- o Tuberculosis

**Any other problems not mentioned above?**

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## PREVIOUS SURGERIES & DATES

| **Procedure:** | **Date:** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## MEDICATIONS

**Please list all medications (including supplements):**

_____ _____

_____ _____

_____ _____

**Any known allergies? If so, please describe:**

_____

_____

## SOCIAL HISTORY

**Tobacco use:** _____ **Illicit drug use:** _____

**Any other issues:**

_____

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## FAMILY HISTORY

**Phone:** _____ **email (if available):** _____
**Mother:** _____ **Father:** _____ **Brother(s):** _____

**Sister(s):** _____ **Other:** _____

**First Degree Family Members:** _____

**Family History of Sudden Cardiac Death:** _____

**Family History of Congenital Heart Defects (Heart Defects at Birth):** _____

**Family History of Premature Heart Attack:** _____

**Other problems:** _____

**Any other concerns or issues not mentioned above? Please describe:** _____

_____

_____

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Journey Medical, LLC to release the following information: Appointment Notices, Prescription and Sample Pick-up, Lab Results, Inquires on Insurance Information, and Notices of Collections to the specified individuals listed below. Before Journey Medical will release any private health information, the following individuals will have to verify relationship and knowledge of patient.

**Name:** _____ **Relationship:** _____

**Phone:** _____ **email (if available):** _____

**Name:** _____ **Relationship:** _____

**Phone:** _____ **email (if available):** _____

## PAYMENT

I hereby authorize payment to any and all physicians involved in my treatment or diagnosis of my benefits specified and otherwise payable to me, but not exceed the reasonable and customary, charges. I understand that I am financially responsible for charges.

You have the right to request any specific changes deviating from above procedure and how you would like us to restrict your protected health information in disclosing to any individuals or institutions. If you would like us to make specific restrictions, please ask one of the staff to assist you with your request. For this, you may need to fill out an additional form that specifies the requested restrictions. (Form to Request Restrictions on Use and Disclosure of Protected Health Information).

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To all of our valued patients: In order to continue providing you with our services, all payments must be paid for at the time of your visit, prior to the services rendered. Please Note: If you are currently going through a financial hardship, please notify us of your circumstances at the time of your visit. We will listen to you and try to help you arrange an alternative to meet your financial responsibility.

## ASSIGNMENT AND RELEASE

I, _____, the undersigned, certify that I (or my dependent) listed above assign directly to Journey Medical, LLC/Erol Lale, all payments payable by me for services rendered. I understand that I am financially responsible for all charges.

_____ **Date:** _____
(Patient Signature)

_____ **Date:** _____
(Parent/Legal Guardian or Patient Authorized Representative)

**Prepared by:** _____

_____ **Date:** _____