Patient Information

☐ Gary F. Strebel, M.D. ☐ Julie A. Strebel, M.D. ☐ Amber Medico APRN.

Patient's Full Name: _____ Spouse: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: ( ) _____-_____ Work: ( ) _____-_____ Cell: ( ) _____-_____

Date Of Birth: _____/_____/_____ Age:_____ SSN: _____-_____-_____ Marital status: S M W D

Patient's Employer/School: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent Employer: _____ Occupation: _____

Work Phone: ( ) _____-_____ Address: _____

Date Of Birth: _____/_____/_____ Age:_____ SSN: _____-_____-_____

Next of Kin: _____ Relationship: _____ Phone: ( ) _____-_____
(Not living with you)

Address: _____ City: _____ State: _____ Zip: _____

Name Of Person Responsible for Bill: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Whom may we thank for referring you to our office? _____

Pharmacy: _____ Address:_____ Phone:_____

Insurance Information

Do you have INSURANCE or are you SELF PAY? (circle one)

(Primary)Name on Card: _____ Date of Birth: _____/_____/_____

(Secondary)Name on Card: _____Date of Birth: _____/_____/_____

All professional services not paid by your insurance, if applicable, are charged to the patient. You will be given the necessary forms with which to file your insurance if needed. It is office policy to collect payment when services are rendered. Co-payments are expected to be paid at time of service. PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATION AND ASSIGNMENT:

·INSURANCE AUTHORIZATION AND ASSIGNMENT·

I hereby authorize (**circle one**) Amber Medico APRN., Gary Strebel, M.D., Julie Strebel, M.D., to furnish information to my insurance carrier concerning my illness and treatments and I hereby assign to the doctor all payments for medical services rendered to myself or any dependents. I understand that I am responsible for any amount not covered by insurance.

PATIENT SIGNATURE: _____ **DATE:** _____
(A photocopy of this authorization and assignment shall be considered as valid as the original)

PLEASE COMPLETE THE OTHER SIDE

MENSTRUAL HISTORY: AGE OF FIRST PERIOD: _____
PERIOD INTERVAL: # DAYS: _____ # DAYS OF FLOW: _____ MENSTRUAL CRAMPS? _____
BLOOD CLOTS? _____ LOWER BACKACHE? _____ FIRST DAY LAST PERIOD: _____
DATE LAST PAP SMEAR: _____ RESULTS: _____
DATE LAST MAMMOGRAM: _____ RESULTS: _____

PREGNANCY HISTORY:
OF LIVEBIRTHS: _____ # OF TOTAL PREGNANCIES: _____ # OF MISCARRIAGES: _____

DATES OF BIRTH OF CHILDREN, INCLUDING ANY MISCARRIAGES:

_____
_____
_____

PAST HISTORY, PRESENT ILLNESS, INCLUDING FRACTURES: (i.e. Mono, Pneumonia, Hepatitis, Hypertension, Diabetes, Arthritis, Heart Disease, Seizures, Covid etc.)

_____
_____
_____

SURGERIES: (List type of surgery, date, physician and/or hospital, if known.)

_____
_____
_____

FAMILY HISTORY: (Include parents, grandparents, aunts, uncles, Etc.)

TUBERCULOSIS: _____

CANCER: _____

DIABETES: _____

HEART DISEASE, HYPERTENSION/STROKE: _____

OTHER: _____

LIST ALL MEDICATIONS:

_____
_____
_____

CONTRACEPTION: _____ ARE YOU SEXUALLY ACTIVE: _____
FAMILY PHYSICIAN: _____ DO YOU SMOKE? _____
HEIGHT: _____ft. _____in. DO YOU USE ALCOHOL? _____
CIRCLE ONE: OCCASIONALLY RARELY NOT AT ALL

HAVE YOU EVER OR DO YOU CURRENTLY USE ANY TYPE OF STREET DRUGS: _____

ARE YOU ALLERGIC TO ANY MEDICATIONS: YES or NO
PLEASE LIST ALL ALLERGIES (i.e. allergies to medications, food, latex, etc.)

_____
_____

HAVE YOU EVER HAD CANCER: (if so, kind, type of treatment, who treated you, when did it occur, etc.)

_____

REASON FOR VISIT:

_____
_____