



MISSION FAMILY MEDICINE

1785 Garden Street Titusville, FL 32796
Phone: 321-269-9612 Fax: 321-269-8433

**B. Grant Marshall, MD M. Brittany Marshall, MD
Matt Baker, PA-C**

New Patient Form

Name: _____

DOB: _____

Contact Number: _____

Email Address: _____

Address: _____

Insurance (please provide type, group number, and member ID):

Medical Conditions:

Medications:



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www.missionfamilymed.com

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Adult Patient Registration

Patient Name: _____ Sex: M F Date of Birth: ___/___/___

Address: _____
Street City/Town State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext.: _____

Emergency Contact: _____ () _____
Name Phone Number

Insurance Carrier: _____ Policy Holder Name: _____
Policy Number: _____ Your relation to Policy Holder _____

I agree to allow Mission Family Medicine to send a bill for treatment(s) to my insurance carrier:

Patient signature: _____ Date ___/___/___

Former Primary Care Provider: _____ () _____
Name Address Phone number

Please list below any specialists you see/have seen, and contact information if possible:

ADVANCE DIRECTIVES

Do you have a living will? Yes No

Do you have a health care proxy? Yes No Name/Phone# _____

Have you designated someone "Power of Attorney?" Yes No Name/Phone# _____

Have you issued an order indicating "Do Not Resuscitate" (DNR) Yes No

Please give your provider any documentation you have available regarding the above directives.

PAST MEDICAL HISTORY

Check one for each box...Yes or No

Condition	Y	N	Condition	Y	N
Seasonal Allergies			Shingles		
Anemia			Thyroid Disease		
Asthma			High Cholesterol		
Arthritis			Kidney Problems		
Migraines			Liver Disease		
Blood Transfusion			Diabetes		
Cancer(type)			Osteoporosis		
Cataracts			Mental Illness		
CHF/Heart Failure			Dementia		
Heart Murmur			Anxiety		
Heart Attack year: _____			Depression		
High Blood Pressure			Nerve/Muscle Disease		
Blood Clot			Stroke		
Bleeding Disorder			Substance Abuse		
COPD/Emphysema			Seizure Disorder		
Tuberculosis			HIV/AIDS		
Meningitis			Sexually Transmitted Disease		

List others below:

Patient Name _____ Date of Birth ____/____/____

Hospitalizations

Year	Reason	Facility

Obstetric/Gynecologic History For Women

Age of first menstrual period ____ Last menstrual period ____ Period Frequency ____ Age of menopause ____

Total Number of Pregnancies ____ Number of Living children ____

Full Term ____ Premature ____ Miscarriages ____ Abortions ____

Personal Background

Gender Identity: _____ Sexual Orientation: _____ Ethnicity: _____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Separated ____

Occupation: _____ Employer: _____

Unemployed ____ Retired ____ Disabled ____ Cause of Disability: _____

Tobacco Use: Yes ____ No ____ Former ____ Type _____ #Years ____ # Packs/Day ____ # Year Quit ____

Alcohol Use: Yes ____ No ____ Former ____ Type _____ Amount _____ Frequency _____ Abuse Yes/No

Drug Use: Yes ____ No ____ Former ____ Type _____ IV Drugs - Yes/No Rehab - Yes/No



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Test Results and Authorization Form

Patient authorization for use and disclosure of Protected Health Information (PHI)

I authorize Mission Family Medicine Staff to leave a message regarding my medical care at the following telephone number(s):

Telephone _____

Telephone _____

I authorize Mission Family Medicine Staff to discuss or leave a message regarding my medical care with the following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Patient Name

Date of Birth

Signature

Signature Parent/Guardian