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 • Renee Soucier, MD
Matt Baker, PA-C • Kylie Woodhouse, ARNP

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/MuscleDisease		
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 ___/____/_____

Please provide any additional details regarding those condition(s) where you marked "yes":

____

____

____

HEALTH MAINTENANCE HISTORY (Please indicate date of last exam/test)

	Date		Date		Date
Complete Physical Exam		Colonoscopy		Gardasil (HPV) Vaccine	
Pap Smear		Eye Exam		Shingles Vaccine	
Mammogram		Tetanus		EKG	
Bone Density Scan		Pneumovax		Chest X-ray	
PSA test (prostate blood test)		Influenza		Dental Exam	
Rectal Exam		TB test			

Medication Allergies (include reaction):

____

____

Medications (Includes birth control, over the counter, vitamins, supplements, and herbal remedies)

Preferred Pharmacy: ____

Name Dose Frequency Reason For Use

____

____

____

____

____

____

____

____

____

____

Surgeries: (include year)

____

____

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

Family Medical History:

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Dad	Dad's Mom	Other Relative
Alcoholism / Drug abuse									
Alzheimers									
Autoimmune Disease									
Bleeding or Clotting Disorder									
Cancer Breast									
Cancer Colon									
Cancer Ovarian									
Cancer Prostate									
Cancer Other Type									
Coronary Artery Disease (e.g. heart attack, angina)									
Depression / Suicide / Anxiety									
Diabetes									
Genetic Disorder (explain)									
Heart Disease									
High Blood Pressure - Hypertension									
High Cholesterol									
Hypothyroidism / Thyroid Disease									
Kidney Disease									
Kidney Stones									
Osteoporsis									
Other (list below)									
If deceased, put age and cause									

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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