New Patient Data Form

Welcome to Our Office--Simon Direct Primary Care

Please complete the following questionnaire. This will become part of your office record and will be held in strict confidence.

Date _____

Patient Data Form Enrollment can also be done online at www.simonclinic.com

Information on patient

Name (Mr/Mrs/Miss/Dr) _____
Last name First name MI

Nickname _____

Sex: □ Male □ Female

Home address _____

City _____ State _____ ZIP _____

Email _____

Home phone _____ Work phone _____Cell Phone_____

Date of birth _____ Race_____ Primary Language_____

Occupation _____

Physician _____

Referred by _____ Relationship to referring person _____

Information on party responsible for payment

□ Check here if this information is the same as in the box above.

Name_____

Home address _____

City _____ State _____ ZIP _____

Home phone _____ Work phone _____

Date of birth _____ SS # _____

Employer _____

Relationship to patient_____

Group and Insurance Information

1. Are you part of a company or group that will be partially paying for your medical care? Yes/No

Name of company or group _____

2. Do you have health insurance that you would like on file for ordering services outside the clinic such as CT scans, specialists visits, etc? Yes/No

Insurance Company _____

Policy number _____ Group number _____

I understand Rebecca L. Simon M.D., PA will not bill my insurance for services provided in this office.

I agree to be responsible for any charges for services and materials supplied by Rebecca L. Simon M.D., PA and its doctors for the above patient.

_____

Signature of party responsible for payment Date

Consent for Electronic Communication

I consent to have my doctor, or any other agency retained by the facility, such as Quest or other lab, a collection agency, or other affiliated business to communicate with me through potentially non-secure methods-telephone, SMS and email at any number given by me or associated with my account. This may be regarding return messages, results, or bills owed on my accounts. My doctor will never publicly divulge information about me via these services, but by checking this box, I allow for the rapid responses that are inherent to their nature. Patients find it quite useful for simple questions, scheduling, and account notifications. I understand, acknowledge, and agree that the clinic or any agency retained by the facility may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages.

Initials _____

Preferred Contact Method (circle one) SMS/Email

Emergency contacts

Name _____ Phone # _____ Relationship _____

Name _____ Phone # _____ Relationship _____

Current Medications and doses (including over-the-counter and herbal medications)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please attach separate paper if more space is needed

Preferred Pharmacy_____

Immunizations – please state year of most recent dose

Hepatitis B series _____ Gardasil series _____ Chicken Pox (shot or disease) _____
Pneumonia _____ Flu _____ TB screening _____ Tetanus _____
Covid_____type and number of injections_____

Health Maintenance – please state year of most recent test and if it was normal or abnormal

Bone Density _____ (N or A) Colonoscopy _____ (N or A)

Eye exam _____ (N or A) Mammogram _____ (N or A)

Pap smear _____ (N or A) Physical _____ (N or A)

Social History

Occupation _____

Marital status Single/Married/Divorced/Separated/Widowed

Tobacco User? Yes/No

Quit tobacco? Year _____

If current user, choose: Smoker, _____ packs per day or Smokeless tobacco

Alcohol? Yes/No

In recovery? Yes/No

Last use: _____ If current user, how many drinks per day? _____ Per week? _____

Caffeine use? Yes/No If yes, how many drinks per day? _____

Recreational drugs use? Yes/No

In recovery? Yes/No Last use: _____ If yes for current use or recovery, please describe use: _____

Special Diet? Yes/No Please describe _____

Regular exercise? Yes/No Please describe _____

Sexually active? Yes/No With men/women/both?

OB/Gyn History

Age of first period _____

Menopausal? Yes/No

Abnormal pap? Yes/No

Painful periods? Yes/No

Regular periods? Yes/No

PMS symptoms? Yes/No

Pain with intercourse? Yes/No

Content with sex life? Yes/No

Number of pregnancies _____ Full term _____ Preterm _____ Miscarriages _____ Abortions _____ Tubal pregnancies _____

Infertility issues? Yes/No

Health History – check all that apply

Abnormal EKG		Urinary Tract Infections		Anxiety	
Diarrhea		Urinary Incontinence		Depression	
Anemia		Erectile Dysfunction		ADD/ADHD	
Chest pain		Kidney Disease		Memory Loss/Dementia	
Peripheral Vascular Disease		Kidney Stones		History of Concussion	
Blood Clots		Sexually Transmitted infection		Psychiatric History (OCD, Schizophrenia	
Heart Attack		Skin Disease		Suicidal Attempts	
Heart Disease (CHF)		Psoriasis		Hearing loss	
High Cholesterol		Melanoma		Eye problems	
Diabetes		Emphysema/COPD		Headaches	
Hypertension		Obstructive Sleep Apnea		Migraine Headaches	
Gallbladder Disease		Asthma		Epilepsy/Seizures	
Liver Disease		Osteoarthritis		Tremor	
Ulcerative Colitis/Crohn's		Rheumatoid Arthritis		Parkinson's Disease	
Hernia		Gout		Other Neurologic disease	
Pancreatitis		Neck or spine problems		Cancer	
Irritable Bowel Syndrome		Sickle Cell Disease		Sinus disease	
Chronic constipation		Stroke		Seasonal Allergies	
Acid Reflux/Ulcers		Thyroid disease		Other-Please List	

Surgical History – please include year of surgery

Tonsillectomy _____ Gallbladder removal _____ Hysterectomy _____

Joint replacement _____ Appendectomy _____ Heart cath _____

Heart stent _____ Colonoscopy _____ EGD _____

Spine surgery _____ Breast biopsy _____ Prostate surgery _____

Hernia repair _____ Carpal tunnel release _____ Cesarean section _____

Ear tubes _____ Other_____

Allergies – please list reaction

_____ _____

_____ _____

Please attach separate paper if more space is needed

Family History

Adopted? Yes/No

Illness	Father	Mother	Sibling	Child	Aunt/Uncle/Grandparent
Epilepsy					
Bleeding Disorder					
Breast Cancer					
Colon Cancer					
Bladder Cancer					
Prostate Cancer					
Ovarian Cancer					
Cervical Cancer					
Lung Cancer					
Brain Cancer					
COPD/Asthma					
Diabetes					
High Cholesterol					
Heart Disease					
High blood pressure					
Heart Attack					
Stroke					
Depression/Anxiety					
Drug/Alcohol Addiction					
Autoimmune Disease					
Kidney Disease					
Osteoporosis					
Liver Disease					
Thyroid disease					

Office use only: Terms of Service Agreement completed _____ History form_____

Consent for telehealth treatment_____ HIPPA and Privacy completed and scanned_____

Privacy Policy Acknowledgement_____ Records Release _____