Disclaimer: Thank you for your interest in becoming a patient of HUTTO WELLNESS. This form is used to collect information about new patients and used for internal purposes only. The information you supply is confidential and will be treated accordingly.

PATIENT DETAILS

First Name: _____ **Last Name**: _____

Date of Birth: _____ **Gender**: ☐ Male ☐ Female ☐ Other

Street Address: _____

City: _____ **State**: _____ **ZIP Code**: _____

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

SS# or Driver's License #: _____**E-Mail**: _____

Ethnicity/Race: _____ **Weight**: _____ **Height**: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

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

Spouse Name: _____ **Spouse Phone**: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship: _____ **E-Mail**: _____

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

TREATING PHYSICIANS

List all other active treating physicians:

Physician Name: _____**Specialty**: _____**Phone#:**_____

Physician Name: _____**Specialty**: _____**Phone#:**_____

Physician Name: _____**Specialty**: _____**Phone#:**_____

ALLERGIES

List your allergies and describe the reactions to your body:

Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____
Allergy: _____ **Reaction**: _____

MEDICATION LIST

List the medications you are currently taking including the dosage: ☐ I brought a List.

Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____
Medication: _____ **Dose**: _____

FAMILY HEALTH HISTORY

Circle any major conditions/illnesses that your immediate family members have had:

Diabetes	Cancer	Arthritis	High Blood Pressure	Asthma
COPD	Stoke/CVA	Kidney	Heart Disease	Thyroid Disorder

List Others: _____

_____

SURGICAL HISTORY

Circle any surgeries, fractures, major illnesses, or hospitalizations that you have had:

Appendectomy	Hysterectomy	Tubal Ligation	Ovary 1 or 2
Lung	Breast	Back	Neck
Tonsils	Adenoids	Brain	Heart Valve
Heart Bypass	Pacemaker	Hernia	Gallbladder
Thyroid	Stomach	Colon	Spleen
Skin	Prostate	Sinus	Kidney
Pancreas	Eye	Joints	

List Others: _____

_____

MEDICAL HISTORY

Have you ever had any of the following?

Anemia
Arthritis Conditions
Asthma
Atrial Fibrillation
Bleeding Problems
Benign Prostatic Hypertrophy
Coronary Artery Disease
Cancer
Cardiac Arrest
Celiac Disease
Chest Pain
Congestive Heart Failure
Chronic Fatigue Syndrome
Depression
Diabetes
Drug/Alcohol Abuse
Erectile Dysfunction
Fibromyalgia
Gerd
Heart Disease
Hyperinsulinemia
Hyperlipidemia
Hypertension
Male Hypogonadism
Hypothyroidism
Infection Problems
Insomnia
Irritable Bowel Syndrome
Kidney Problems
Menopause
Migraines/Headaches
Neuropathy
Onychomycosis
Organ Injury
Pulmonary Embolism
Seizure Disorders
Shortness of Breath
Sinus Conditions
Osteoporosis
Stroke
Syndrome X
Tremors
Wheat Allergy

List Others:
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you use alcohol? ☐ Yes ☐ No / How many drinks per week? _____
Do you currently smoke? ☐ Yes ☐ No
☐ Tobacco ☐ Marijuana ☐ Other: _____How much per day? _____
Do you currently use any other drugs? ☐ Yes ☐ No

PREFERRED PHARMACY

Pharmacy Name: _____ **Phone**: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____

PATIENT CONSENT

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.
b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.
c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.
d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.
e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.
f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date**: _____

Print Name: _____