

Quality care you deserve.

good health

family medicine

1339 West 6th Street, Erie, PA 16505
Telephone 814-480-8170
FAX 814-480-8175

PATIENT INFORMATION:

LAST NAME _____ FIRSTNAME _____ MI _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ CELLPHONE _____
BIRTHDATE _____ SOC SEC# _____
MARITAL STATUS: S M W D E-MAIL ADDRESS _____
EMPLOYER _____ WORKPHONE _____
WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
JOB DESCRIPTION: _____

INSURANCE SUBSCRIBER INFORMATION:

(CHECK IF SAME AS ABOVE)

LAST NAME _____ FIRSTNAME _____ MI _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ CELLPHONE _____
BIRTHDATE _____ SOC SEC# _____
MARITAL STATUS: S M W D E-MAIL ADDRESS _____
EMPLOYER _____ WORKPHONE _____
WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
JOB DESCRIPTION: _____

GUARANTOR INFORMATION: person responsible for payment

(CHECK IF SAME AS PATIENT OR INSURANCE SUBSCRIBER)

LAST NAME _____ FIRSTNAME _____ MI _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ CELLPHONE _____
BIRTHDATE _____ SOC SEC# _____
MARITAL STATUS: S M W D E-MAIL ADDRESS _____
EMPLOYER _____ WORKPHONE _____
WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
JOB DESCRIPTION: _____

How did you hear about us? _____



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

THIS AUTHORIZATION OR PHOTOCOPY HERE OF, AUTHORIZES

TO FURNISH ALL INFORMATION THEY MAY HAVE REGARDING MY (OUR) CONDITION(S) WHILE UNDER THEIR DOCTOR OBSERVATION OR TREATMENT. INCLUDING, BUT NOT LIMITED TO, HISTORY OBTAINED, RADIOLOGIST, LABORATORY AND PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS.

I UNDERSTAND THIS RELEASE WILL NOT RESTRICT THE DISCLOSURE OF INFORMATION PERTAINING TO DRUG OR ALCOHOL ABUSE, PSYCHIATRIC CONDITIONS, A BLOOD TEST FOR AIDS OR AN AIDS DIAGNOSIS AND TREATMENT.

PLEASE TRANSFER MY COMPLETE MEDICAL RECORDS TO:

GOOD HEALTH FAMILY MEDICINE
DR. MICHELE POLON
1339 W. 6TH STREET
ERIE, PA 16505

NAME OF PATIENT	DATE OF BIRTH
1.	
2.	
3.	
4.	
5.	
6.	

SIGNED: _____ DATE: _____

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PATIENT NAME: _____ **DOB:** _____

Appointment Date/Time with Dr Michele Polon: _____

Social History:

Marital Status: married, single, widowed, divorced, in a long term relationship

Education Level: grade school, high school, GED, college, advanced degree

Tobacco: non-smoker, ex-smoker year quit _____, current smoker/chew user _____ Packs/cans per day,
 cigar smoker _____ cigars per day

Alcohol: Abstains, alcohol usage...beer _____ cans per day/week, wine _____ glasses per day/week,
mixed drinks _____ per day/week

Drug use: marijuana, barbiturates, cocaine, narcotics, other _____

Past Medical History:

Chronic problems:

	Year Diagnosed	Other Problems	Year Diagnosed
Arthritis			
Cancer			
COPD/Emphysema			
CVA or stroke			
Depression			
Diabetes, Type 1			
Diabetes, Type 2			
GERD			
Heart Disease			
Hyperlipidemia			
Hypertension			
Kidney Stones			
Mental illness			
Migraines			
Sleep Apnea			
Thyroid disease			

Living Will: Do you have a Living Will? Yes No ...if yes, we need a copy.

FAMILY HISTORY:

	None	Mother	Father	Sibling add name	Maternal Grand- Mother	Maternal Grand- Father	Paternal Grand- Mother	Paternal Grand- Father	Other
Living (L) or Deceased (D)									
Cancer (specify type)									
COPD									
CVA or Stroke									
Depression									
Diabetes, Type 1									
Diabetes, Type 2									
Immune Deficiency									
Heart Disease									
Hyperlipidemia									
Hypertension									
Mental illness									
Myocardial Infarction									
Thyroid disease									

For Females only:

Past OB/GYN History:

Menarche: age at onset of menstrual period: _____

Menopause: N/A, Natural at age _____, Surgical at age _____ (list surgery above)

History of Birth Control. none Currently Using Prior Usage

	Currently Using	Prior Usage
Birth Control Patch		
Condoms		
Depo-Provera Shots		
Diaphragm		
Implants		
IUD		
NuvaRing		
Oral contraceptives		
Vasectomy		

Regular **GYNECOLOGIST** is: Dr Polon, other: _____

Pregnancy History:

Do you have any children: Yes No

Name:	Date of Birth:	Vaginal or Cesarean Delivery
	M/F	
	M/F	
	M/F	

Please fax or mail this Health History form to our office, prior to your appointment.

Please bring the following with you to your appointment:

1. Insurance Cards
2. Immunization Record
3. Living Will/Power of Attorney, if applicable
4. Patient Data form (this can be faxed or mailed also)
5. Records Release form (this can be faxed or mailed also)

We look forward to seeing you and maintaining your good health.

All forms, along with our office policies can be printed from our website or requested from our staff.

WWW.goodhealthfamilymedicine.com