PATIENT INFORMATION

Coury Family Medicine

5424 E. Southern Avenue, Suite 101, Mesa, AZ 85206 Phone: 480-654-6200 Fax: 480-654-6214
1520 W. Guadalupe Rd. Suite 108, Gilbert, AZ 85233 Phone: 480-633-6200 Fax: 480-654-6214

Patient Name: (Last)_____ (First)_____ (MI)____

Address: _____ **Apt/Space #**: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____/_____/_____ **Male**: ☐ **Female:** ☐ **Soc. Sec. Number**: _____ - _____ - _____

Home #: (____) _____ - _____ **Work #**: (____) _____ - _____ **Cell #**: (____) _____ - _____

Email: _____ **Preferred phone number:** Home Work Cell

How would you prefer to receive messages?

Phone Patient Portal – electronic (requires valid email address)

Pharmacy: (Local with cross streets)

_____(MailOrder)_____

Race: American Indian Asian Black or African American White Hispanic
Native Hawaiian Pacific Islander White Alaskan Do not wish to respond

Ethnicity: Not Hispanic Hispanic, Latino/a Do not wish to respond

Language Preference: English Other_____ Do not wish to respond

Marital Status: Married Single Widowed Separated Divorced Do not wish to respond

Name of Spouse: _____ **Referred by**: _____

Emergency Contact (Name and Phone): _____

Do you have a Living Will? Yes No **Do you have a Power of Attorney?** Yes No

Do you leave for the summer? Yes No **What months are you in Arizona?** _____ to _____

Summer Address: _____ **City:** _____ **State:** ____ **Zip:**_____

AUTHORIZATION & RELEASE

I authorize release of any information concerning my (or my minor child's) health care, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X_____ Date: _____

RESPONSIBLE PARTY INFORMATION

Name:	Home Phone:	Work Phone:
Address:		
City:	State/Prov.	Zip Code:

INSURANCE INFORMATION

Name of Insured:		Relation to Patient:
Name of Insurance:		Name of Employer:
ID No.:	Group No.:	Date of Birth: _____/_____/_____

SECONDARY INSURANCE INFORMATION

Name of Insured:		Relation to Patient:
Name of Insurance:		Name of Employer:
ID No.:	Group No.:	Date of Birth: _____/_____/_____

Medical History

CURRENT MEDICATIONS (INCLUDE PRESCRIPTION AND OTC) ☐ **See Attached List**

Name of Medication	Dosage	How Often Taken

ALLERGIES TO MEDICATIONS

Name of Medication	Type of Reaction

LIST ALL SERIOUS INJURIES, ILLNESSES OR SURGERIES

Date (Year)	Injury, Illnesses, Surgeries (Operations)

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			

SOCIAL HISTORY

Do you use the following?	Yes	No	How Much & How Long?
Tobacco			
Alcohol			
Street Drugs			

Female Patients Only	Yes	No	Date
Are you pregnant?			
Children? How Many?			
Hysterectomy? Last Period?			

HEALTH MAINTENANCE

Test	Date
General physical	
Cholesterol Level	
TB test	

Test	Date
Tetanus booster	
Flu vaccine	
Pneumonia vaccine	

Test	Date
Colonoscopy	
Rectal Exam	
PSA (Males)	

Test	Date
Bone Density Exam	
Mammogram (Females)	
Pap Smear (Females)	

ARE YOU CURRENTLY UNDER THE CARE OF ANY SPECIALISTS?

Physician's name	Medical Specialty