E David Pampe, M.D.

Triple i / CliniForms

Patient Registration

Name ____________________ SS# ____________

Street Address ____________________ Date of birth __________ Marital status: S M W Sep D

City ____________________ State __________ Zip __________

Telephone: Home ____________________ Office ____________________

Referred by ____________________

Spouse's name ____________________

Spouse's employer / address ____________________

Emergency contact ____________________ Tel# __________ Relationship __________

Patient Employer Information

Employer name ____________________ Tel# ____________________

Employer street address ____________________ City / State __________ Zip __________

Patients occupation ____________________

Insured Person (if not patient)

Name ____________________ Tel# ____________________

Street Address ____________________ City / State __________ Zip __________

Relationship to patient ____________________

Insurance

Medicaid # (if applicable) ____________________ Medicare # (if applicable) ____________________

Primary Insurance Company Name ____________________

ID # ____________________ Group # __________ Tel.# __________

Secondary Insurance Company Name ____________________

ID # ____________________ Group # __________ Tel.# __________

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date ____________________ Signature ____________________

I hereby authorize Dr. Pampe to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. Pampe (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date ____________________ Signature ____________________
(Patient, parent, or guardian)

Miscellaneous Notes

____

____

____

____

____

Name

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History & Physical

Name ______________________ SS# ____________ Date ________

Address ______________________ Occupation ______________________

Phone (home) ____________ (work) ____________ Date of birth ____________ Age ____

Chief complaint ____

Drug Allergies

____

____

____

____

Current Meds

____

____

____

____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

Hospitalization or Surgery

Reason	Date	Reason	Date

Medical History

- ❑ Headache ______
- ❑ Shortness of breath ______
- ❑ Heart palpitations ______
- ❑ Heart murmur ______
- ❑ Chest pain ______
- ❑ Dizziness/Fainting ______
- ❑ Peripheral vascular disease ______
- ❑ Allergies/Hay fever ______
- ❑ Asthma ______
- ❑ Bronchitis ______
- ❑ Pneumonia ______
- ❑ Ulcer ______
- ❑ GI disorder ______
- ❑ Lactose intolerance ______
- ❑ Gallbladder disease ______
- ❑ Prostate disease ______
- ❑ Bowel irregularity ______
- ❑ Incontinence ______
- ❑ Sexual/menstrual dysfunction ______
- ❑ Venereal disease ______
- ❑ Frequent infections ______
- ❑ Hepatitis ______
- ❑ Anemia ______
- ❑ Arthritis ______
- ❑ Osteoporosis ______
- ❑ Nervousness ______
- ❑ Depression ______
- ❑ Gout ______
- ❑ Scarlet fever ______
- ❑ Chronic rashes ______
- ❑ Rheumatic fever ______
- ❑ Mumps ______
- ❑ Measles ______
- ❑ Rubella ______
- ❑ Polio ______
- ❑ Diphtheria ______
- ❑ Tetanus ______
- ❑ Other ______
- ❑ Other ______

Women only: Pregnant? ❑ Yes ❑ No Planning pregnancy? ❑ Yes ❑ No

Men only: *It's common for men to occasionally experience erection difficulties. Is this something that happens to you?* ❑ *Yes* ❑ *No*
How often does this occur? ❑ *Frequently* ❑ *Sometimes* ❑ *Rarely*

Habits

❑ Smoke: Packs daily ______
How long? ______
Interested in stopping? ______

❑ Exercise routine: ______

❑ Coffee: Cups daily ______
Other caffeine ______

❑ Alcohol: Type ______
Amount ______

❑ Diet: Salt intake ______
Fat intake ______

❑ Sleep: Difficulty falling asleep ______
Continuity disturbances ______
Snoring ______
Early morning awakening ______
Daytime drowsiness ______
Other ______

Name ______

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