Mooresville PPM, LLC

Outpatient Information

PATIENT INFORMATION	Account #:		Medical Record#:	Date:	
Patient Name:			Referring Doctor:		
Billing Address:			City	State	Zip ___
Physical Address:			City	State	Zip ___
(H) Phone:	(C) Phone:		Work Phone:	Other:	
Primary Doctor			Employer/School:		
Social Security #:	Date of Birth:	Age	Marital Status:	Sex:	
Emergency Contact:	Relationship:		(H) Phone:	(C) Phone:	
Responsible Party:	Relationship:		DOB:	SS#:	
Email (responsible party if minor/child)					
Responsible Party Address:					
City:	State	Zip ___	(H) Phone:	(C) Phone:	
INSURANCE INFORMATION					
Primary Insurance:	Employer:		Secondary Insurance:	Employer:	
Insurance ID #:	Insurance Group #:		Insurance ID #:	Insurance Group #:	
Insured Name:			Insured Name:		
Address:			Address:		
City	State	Zip ___	City	State	Zip ___
DOB:	Insured Social Security #:		Insured DOB:	Insured Social Security #:	

Financial Responsibility and Assignment of Insurance Benefits:

I guarantee payment to Mooresville PPM, LLC and its affiliates (Mooresville PPM, LLC) of all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Mooresville PPM, LLC for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Signature of Patient or Authorized Person: _____ ***Date/Time:*** _____

Insured Party or Financial Guarantor (if different from above): _____ ***Date/Time:*** _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

❑ Interpreter Accepted _____ ❑ Interpreter Refused

(Name/Number of Person/Services Chosen/Used

Date: _____

Name: _____ **DOB:** _____ **Age:** _____

Referring Physician: _____ Primary Care Physician: _____

Chief Complaint: _____

_____

Past Medical History

_____
_____
_____
_____

Past Surgical History

_____
_____
_____
_____

Please list allergies of any kind, and include reactions: _____

_____

Present Medications (Please include all prescription and non-prescription medications.)

Name	Dose	Name	Dose
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Obstetrical History # of Pregnancies: _____ # of Children: _____ Age at first live birth: _____
Age of menarche: _____ Age of menopause: _____

Social History/Habits Tobacco: Y/N _____ Type _____ Times per day _____
Exercise: Y/N _____ Times per wk _____ Caffeine: _____
Alcohol: Y/N _____ Times per wk _____ Street Drugs: Y/N _____

FAMILY HISTORY:

		If Living			If Deceased	
Relationship	*Age*	*Health*			*Age at Death*	*Cause*
Father		☐ Good	☐ Fair	☐ Poor		
Mother		☐ Good	☐ Fair	☐ Poor		
Brother/Sisters		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		
M / F		☐ Good	☐ Fair	☐ Poor		

Check if any blood relatives (mother, father, brother, sister, aunt, uncle, grandfather, grandmother) have had any of the following:

	YES	NO		YES	NO		YES	NO
Stroke			Epilepsy			Colitis		
Cancer			Emphysema			Rheumatic Heart		
High Blood Pressure			Bleeding Tendency			Congential Heart		
Tuberculosis			Heart Attack			Died Suddenly		
Diabetes			Kidney Disease			Heart Failure		
Leukemia			Arthritis					

Please check indicating if you have or have had problems with any of the following and describe in the space provided.

GENERAL HEALTH	YES	NO	COMMENTS
Fever	☐	☐	
Chills	☐	☐	
Fatigue or tiredness	☐	☐	
Cancer	☐	☐	
Unexplained weight gain or loss	☐	☐	
EYES			
Disease/Injury	☐	☐	
Blurred Vision	☐	☐	
Double Vision	☐	☐	
Glaucoma	☐	☐	
EARS/NOSE/MOUTH/THROAT			
Hearing Loss	☐	☐	
Ringing in the Ears	☐	☐	
Earaches/Drainage	☐	☐	
Nosebleeds	☐	☐	
Chronic Sinus Problems	☐	☐	
Mouth Sores	☐	☐	
Sore Throat	☐	☐	
Voice Changes	☐	☐	
Swollen Neck Glands	☐	☐	
CARDIOVASCULAR			
Heart Trouble	☐	☐	
Chest Pain/Angina	☐	☐	
Rheumatic Fever	☐	☐	
Irregular or fast heartbeat	☐	☐	
High Blood Pressure	☐	☐	
Swelling of Feet/Hands	☐	☐	
RESPIRATORY			
Shortness of Breath	☐	☐	
Coughing	☐	☐	
Spitting up Blood	☐	☐	
Asthma/Wheezing	☐	☐	
GASTROINTESTINAL			
Change in Bowel Movements	☐	☐	
Nausea/Vomiting	☐	☐	
Frequent Diarrhea	☐	☐	
Rectal Bleeding/Blood in Stool	☐	☐	
Abdominal Pain/Heartburn	☐	☐	
Peptic or Stomach Ulcers	☐	☐	
Colitis	☐	☐	
Gallbladder disease	☐	☐	
GENITOURINARY			
Frequent Urination	☐	☐	
Burning/Painful Urination	☐	☐	
Blood in Urine	☐	☐	
Incontinence or Dribbling	☐	☐	
Kidney Stones	☐	☐	
Sexual Difficulty	☐	☐	
Male – Testicle Pain	☐	☐	
Female – Irregular Periods	☐	☐	
Female – Planning pregnancy	☐	☐	
Females – Menopause	☐	☐	
Sexually Transmitted Disease	☐	☐	
MUSCULOSKELETAL			
Joint Pain	☐	☐	
Muscle Pain	☐	☐	
Muscle Weakness	☐	☐	
Joint Stiffness/Cramping	☐	☐	
Gout	☐	☐	
Arthritis	☐	☐	
SKIN/BREAST			
Rash or Itching	☐	☐	
Change in Skin Color	☐	☐	
Change in Hair/Nail Color	☐	☐	
Varicose Veins	☐	☐	
Breast Pain	☐	☐	
Female – Breast Discharge	☐	☐	
NEUROLOGICAL			
Stroke	☐	☐	
Frequent Headaches	☐	☐	
Lightheadedness/Dizziness	☐	☐	
Seizures	☐	☐	
Numbness/Tingling	☐	☐	
Tremors	☐	☐	
Head injury	☐	☐	
Blackout/Loss of Consciousness	☐	☐	
PSYCHIATRIC			
Nervousness	☐	☐	
Depression	☐	☐	
Insomnia	☐	☐	
ENDOCRINE			
Hormone Problem	☐	☐	
Thyroid Disease	☐	☐	
Diabetes	☐	☐	
Excessive Thirst	☐	☐	
Excessive Urination	☐	☐	
Heat/Cold Intolerance	☐	☐	
Dry Skin	☐	☐	
HEMATOLOGY/LYMPHATIC			
Slow to Heal After Cuts	☐	☐	
Bleeding or Bruising Tendency	☐	☐	
Anemia	☐	☐	
Past Transfusions	☐	☐	
Enlarged Glands	☐	☐	
Jaundice	☐	☐	
Hepatitis	☐	☐	
ALLERGIC/IMMUNOLOGIC			
Food Allergies	☐	☐	
Environmental Allergies	☐	☐	
Latex Allergies	☐	☐	

Reviewed by: _____ Initials / Date _____ _____ Initials / Date _____

MOORESVILLE PPM, LLC

Adult History Questionnaire