
CAPSTONE
FAMILY PRACTICE

Capstone Family Practice

2487 S. Michigan Rd. Eaton Rapids, MI 48827
Phone: 517-836-2178 Fax: 517-836-2182

PATIENT DEMOGRAPHICS

Patient Name:		*Date of Birth:*	
Address:	*City:*	*State:*	Zip Code:
Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced	*Sex:*	*Age:*	
Social Security#:	*Preferred Phone#:*	*Secondary Phone#:*	
Email Address:		*Primary Language:*	
Occupation	*Employer*		

Race: (Please check appropriate choice)

( ) White/Caucasian ( ) Asian ( ) American Indian/Alaska Native

( ) Black/African American ( ) Native Hawaiian ( ) Multi-racial ( ) Decline to Report

Ethnicity: (Please check appropriate choice)

( ) Hispanic/Latin American ( ) Non-Hispanic/Latin American ( ) Decline to Report

Responsible Party (Insured) Name:	*Date of Birth:*	*Sex:*	
Address: (If different than patient)	*City:*	*State:*	*Zip Code:*
Preferred Phone#:			

HEALTH INSURANCE INFORMATION

Primary Insurance	*Secondary Insurance*
Carrier Name:	Carrier Name:
Subscriber Name:	Subscriber Name:
Date of Birth:	Date of Birth:
Policy ID:	Policy ID:
Group #:	Group #
Co-Pay:	Co-Pay:

Capstone Family Practice, PLC

Patient Authorization for Personal Representative. Please print all information, then sign and date form at bottom.

Patient Name: _____ **Date of Birth**: _____/_____/_____

Purpose of request: I authorize the practice to disclose or provide my protected health information to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information:

1.) _____
Name of Personal Representative **Phone**

_____
Address **City** **State** **Zip**

2.) _____
Name of Personal Representative **Phone**

_____
Address **City** **State** **Zip**

- Description of information to be disclosed: I authorize the practice to disclose all my protected health information to my designated personal representative.
- Expirations or termination of authorization: This authorization will remain in effect until terminated by you, your personal representative or other individual(s) of legal entity authorized to do so by court order or law.
- Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to:

Attn: Office Manager
Capstone Family Practice
2487 S. Michigan Rd
Eaton Rapids, MI 48827

Redisclosure: We have no control over the person(s) you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of this practice.

_____
Patient **Date**

Copies of signed authorizations are available upon request.

Patient Name: _____

How did you hear of Capstone Family Practice? _____

Who is your current / most recent primary care provider (PCP)? _____

When was your most recent office visit with your PCP? _____

When was your most recent physical? _____

Why are you seeking a new primary care provider? _____

_____

Please list the names of any current or previous specialists (ex: cardiologist) involved in your care, how often and last time you saw your specialist:

_____

_____

_____

Females Age at menarche (onset of menses): _____ Age at menopause: _____

Number of pregnancies: _____ Number of live births: _____ Pregnancy Loss: _____

TEST/PROCEDURE	DATE/YEAR	LOCATION	RESULTS
AAA screen (ultrasound)			
Bone Density(DEXA)scan			
Cardiac Stress Test			
Cervical Cancer Screen (Pap/HPV)			
Colon Cancer Screen (scope or cologuard)			
EGD/Upper GI			
Echocardiogram			
EKG			
Lung Cancer Screen/CT			
Mammogram/Breast MRI/ultrasound(s)			
Pulmonary Function Testing (PFT)			

Patient Name:_____

SURGICAL HISTORY	DATE/YEAR	LOCATION	SURGEON

MEDICATION	DOSE	FREQUENCY	PRESCRIBED BY

ALLERGIES (Medications/Foods/Other)	REACTION

Patient Name:_____

Family History unknown adopted:_____

Please list major illnesses of family members if known. Such as: heart disease, stroke, diabetes, cancers, hypertension, autoimmune disorders, psychiatric conditions.

RELATIVE	MEDICAL ILLNESS/CHRONIC DISEASE	ALIVE	AGE AT DEATH
Father			
Mother			
Brother			
Sister			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			
Other			
Other			

Have you ever smoked tobacco? Yes No Do you currently smoke tobacco? Yes No

How many years did/have you smoked tobacco? _____ How many packs per day____Quit date_____

Current or past use of other forms of tobacco/ nicotine (ie e-cigarette/chew tobacco) Quit date_____/Current use

Are you currently using or participating in the following:

	Yes	No	Type:	Frequency	Amount
Alcohol					
Caffeine (coffee, soda, energy drinks)					
Recreational/Illicit substances					

Do you have an advance directive? YES or NO

What is your code status? FULL CODE, DNR, or OTHER

Do you have an out of hospital DNR? YES or NO

Do you have a medical power of attorney? YES or NO

Do you have a directive to physicians? YES or NO

Do you have a patient advocate? YES or NO

Is blood transfusion acceptable in an emergency? YES or NO OTHER

Patient Name _____

Autoimmune

Ankylosing Spondylitis

Ehlers Danlos Syndrome

Grave's disease/Hashimoto

Rheumatoid arthritis (or JRA)

Sjogren's Syndrome

Polymyalgia Rheumatica

Psoriatic arthritis

Other:_____

Cancer

Type(s)/Year:_____

_____

_____

_____

Cardiovascular

Aortic stenosis

Atrial fibrillation

Angina/Chest pain

Cardiac Stent placement

Cardiac Stress test

Congestive heart failure

Enlarged heart/cardiomyopathy

Heart Ablation

Heart arrhythmia

Heart attack/MI

Heart catheterization

Heart murmur

Heart surgery

High blood pressure

High cholesterol

Pacemaker

Valve disorder

Other: _____

Coagulation Disorders

Anemia, type_____

Blood Transfusion

Clotting disorder, type_____

Deep Vein Thrombosis (DVT)

Hemophilia, type_____

Pulmonary embolism (PE)

Varicose veins

Other:_____

Cognitive

Autism (ASD)

Attention deficit disorder

Dyslexia

Developmental Delay

Learning Disability

Sensory Processing Disorder

Other:_____

Endocrine

Addison's Disease

Adrenal insufficiency

Parathyroid disorder

PCOS

Pituitary disorder

Prediabetes/Metabolic syndrome

Thyroid disorder

Type I Diabetes

Type II Diabetes

Other: _____

Gastrointestinal

Abnormal liver tests

Acid reflux/GERD

Barrett's esophagus

Chronic EBV or CMV

Constipation

Colon polyps

Colostomy/Ileostomy

Diverticulitis/Diverticulosis

Enlarged/fatty liver

Gallbladder problems

Hemorrhoids

Hernia

Hepatitis (Type: A, B, C, D)

IBD(Crohn's or Ulcerative Colitis)

Irritable Bowel Syndrome

Liver Cirrhosis

Spleen problem

Other:_____

Head & Neck

Allergies/Hay fever

Cataracts

Cold sores/Herpes labialis

Cleft palate

Dental decay

Deviated septum

Dysphagia/difficulty swallowing

Enlarged tonsils/adenoids

Glaucoma

Hearing &/or Vision Loss

Speech problems

TMJ

Other:_____

Infectious Disease/Other

Chronic lyme disease

HIV/AIDS/Syphilis

Tuberculosis (TB)

MRSA/VRE

Other:_____

Patient Name _____

Mood/Psychiatric

Anxiety

Depression

Inpatient psychiatric

Bipolar I/II

Borderline personality

Obsessive compulsive

Oppositional Defiant(ODD)

Panic attacks

PTSD

Schizophrenia

Other:_____

Musculoskeletal

Arthritis

Chronic back pain

Chronic neck pain

Fibromyalgia

Osteoporosis

Tendon repair

Gout

Spine disorder

Spine/joint injections

Other:_____

Neurologic

Alzheimer's/Dementia

Chronic headaches (migraine/cluster/tension)

Cognitive Disorder

Hydrocephalus

Multiple Sclerosis/ALS

Neuropathy

Parkinsons

Seizure disorder

Stroke / TIA

Tremors

Other: _____

Pulmonary

Asthma

Cystic Fibrosis

COPD/Emphysema

Lung nodules

Lung CT scans annually

Oxygen (full or part time)

Pulmonary Embolism

Pulmonary Fibrosis

Pulmonary Stenosis

Sleep Apnea/CPAP

Other: _____

Reproductive

Abnormal pap smear

Endometriosis

Erectile Dysfunction

Hormone replacement therapy

Infertility

Priapism

Pre-Eclampsia

Menopause

Menstrual Disorders

Ovarian cysts

Testicular abnormalities

Uterine Fibroids

Uterine or vaginal prolapse

Other:_____

Skin

Abnormal skin lesions

Athlete's foot/tinea pedis

Eczema

Lichen Sclerosis

Psoriasis

Shingles

Skin cancer (basal/squam/melan)

Toenail fungus

Vitiligo

Warts

Other:_____

Urinary/Renal/Prostate

Catheter use/urostomy

Cystocele

Dialysis (hemo or peritoneal)

Kidney/Renal disease

Kidney cysts

Kidney stones

Prostate enlargement

Prostatitis (acute vs chronic)

Urinary frequency

Urinary incontinence

Other: _____