CCMC
CLINTON COUNTY MEDICAL CENTER

New Patient Medical Form

Patient Name: _____
First *Middle Initial* *Last*

Address: _____
Street *City* *State* *Zip Code*

Home Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Work Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Cell Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Gender: [] Female [] Male Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Marital Status: [] Single [] Married [] Divorced [] Windowed [] Separated

Employment Status: [] Full Time [] Part Time [] Not Employed [] Self-employed [] Retired [] Military Duty

Employer Name: _____

Email address: __

Responsible Party Name: (if different than patient)

_____
First *Middle Initial* *Last*

Responsible Party Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Gender: [] Female [] Male Relationship to patient: _____

Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Emergency Contact:

_____
First *Middle Initial* *Last*

Phone: (__ __ __) - ___ ___ ___ - ___ ___ ___ ___

Gender: [] Female [] Male Relationship to patient: _____

Date of Birth: ___ ___/___ ___/___ ___ ___ ___

1005 S. US 27, St. Johns, MI 48879
Phone: 989-224-3000 ~ Fax: 989-224-1424

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Insurance Information

Primary Insurance:

Carrier Name: _____

Subscriber Name: _____

Subscriber Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Certificate Number: _____ Group Number: _____

Patient's Relationship to Subscriber: [] Self [] Spouse [] Child [] Other

Secondary Insurance:

Carrier Name: _____

Subscriber Name: _____

Subscriber Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Certificate Number: _____ Group Number: _____

Patient's Relationship to Subscriber: [] Self [] Spouse [] Child [] Other

Tertiary Insurance:

Carrier Name: _____

Subscriber Name: _____

Subscriber Date of Birth: ___ ___/___ ___/___ ___ ___ ___

Certificate Number: _____ Group Number: _____

Patient's Relationship to Subscriber: [] Self [] Spouse [] Child [] Other

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Name: _____ Date of Birth: ___/___/ _____ Age: ____ Sex: ____
Race: [] American Indian or Alaska Native [] Asian [] Black or African American [] Native Hawaiian or Other Pacific Islander [] White [] Decline to Comment
Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] Decline to Comment
Preferred Language: [] English [] Spanish [] Other: _____

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD/Acid Reflux			
❑ Depression or Anxiety			
❑ Heart Problems -			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦

Medication	*Strength*	*Number of pills taken & frequency*	*Medication*	*Strength*	*Number of pills taken & frequency*
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

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♦ Social, Educational and Work History ♦

Marital Status:	Age of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Do you consume caffeine?	What type of caffeine?	No. of caffeinated drinks per day?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				
Grandmother (mothers side)				
Grandfather (mothers side)				
Grandmother (fathers side):				
Grandfather (fathers side)				

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	
*Pneumonia Vaccine		Pap Smear		Heart Catheterization	
**Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	

*Other names for Pneumonia Vaccine are Prevnar 13 or PneumoVax
**Other name for Tetanus Vaccine is Tdap/Td

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