Hope Health Family Practice
Single Encounter Patient Information Form

DATE OF SERVICE___________________

NAME____ DATE OF BIRTH________________

Male____ Female ____ Marital Status: Married___ Single___Widowed___Divorced___Separated____

HOME ADDRESS: LOCAL ADDRESS/PHONE (if visiting):

_____________________________________ ____

_____________________________________ ____

_____________________________________ ____

PHONE: (HOME) _____________________, (CELL)______________________,(WORK)____________________

HEALTH INSURANCE INFORMATION: SELF PAY_________ INSURED__________________

Company name____

Identification #_____________________________ Group No. ______________________________

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REASON FOR VISIT____

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PRESENT MEDICATIONS/VITAMINS/SUPPLEMENTS: (please include dosage if possible)

____ ____________________________________

____ ____________________________________

____ ____________________________________

ALLERGIES TO MEDICATIONS ____

OTHER NON-MEDICATION ALLERGIES____

PAST MEDICAL HISTORY/SURGERIES/HOSPITALIZATIONS ____

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NAME AND ADDRESS/PHONE/FAX OF PRIMARY CARE PROVIDER:

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