

# Family 1st Urgent & Primary Care

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Phone: 205.795.0010 Fax: 205.543.6872

9288 Stouts Rd, Kimberly AL 35091

## Primary Care Application

Name (First, MI, Last): \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Previous Primary Care Provider: \_\_\_\_\_ (Provider Name)

Office Phone Number: \_\_\_\_\_

Office Address: \_\_\_\_\_

\_\_\_\_\_

Name of Primary Insurance: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_

Relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_

Preferred Pharmacy Name/City: \_\_\_\_\_

\_\_\_\_\_

Language spoken: \_\_\_\_\_



MEDICAL HISTORY (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Hypertension  | <input type="checkbox"/> Hypotension              | <input type="checkbox"/> Aortic Stenosis  |
| <input type="checkbox"/> Atrial Fibrillation   | <input type="checkbox"/> Carotid Stenosis         | <input type="checkbox"/> Heart Disease    |
| <input type="checkbox"/> Heart attack/MI   | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Abdominal Aortic Aneurysm                                       | <input type="checkbox"/> Deep Vein Thrombosis     | <input type="checkbox"/> Stroke/CVA       |
| <input type="checkbox"/> Peripheral Vascular Disease                                     |   |   |
| <input type="checkbox"/> Other Cardiac diagnosis: _____                                  |   |   |
| <input type="checkbox"/> Immediate Family History of Cardiac disease: relation/age _____ |   |   |

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Chronic Cough                    | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma      |
| <input type="checkbox"/> COPD/Emphysema                   | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Tuberculosis                     | <input type="checkbox"/> Pulmonary Embolus   |                                      |
| <input type="checkbox"/> Other Pulmonary diagnosis: _____ |  |                                      |

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Diabetes Type I                  | <input type="checkbox"/> Diabetes Type 2 | <input type="checkbox"/> Hypoglycemia   |
| <input type="checkbox"/> Diabetic Neuropathy              | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Goiter/other thyroid issues      | <input type="checkbox"/> Gout            |   |
| <input type="checkbox"/> Other Metabolic disorders: _____ |  |   |

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Crohn's Disease                         | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Ulcer Disease                           | <input type="checkbox"/> Hiatal Hernia            | <input type="checkbox"/> Gall Stones    |
| <input type="checkbox"/> Cirrhosis                               | <input type="checkbox"/> Ulcerative Colitis       | <input type="checkbox"/> Reflux         |
| <input type="checkbox"/> Liver Disease                           | <input type="checkbox"/> Pancreatitis             |   |
| <input type="checkbox"/> Other Gastrointestinal disorders: _____ |   |   |

Kidney Disease: Stage \_\_\_\_\_  Dialysis

Other Renal disorders: \_\_\_\_\_

Kidney Stones  Urine Incontinence

Other Urinary disorders: \_\_\_\_\_

BPH  Epididymitis  Erectile Dysfunction

Prostatitis  Testicular Problems  Hypogonadism

Sexually Transmitted Disease: \_\_\_\_\_

Other Male disorders: \_\_\_\_\_

Ovarian Cyst  Pelvis inflammatory Disease  Breast Disease

Ectopic Pregnancy  Sexually Transmitted Disease: \_\_\_\_\_

Other Female disorders: \_\_\_\_\_

Rheumatoid Arthritis  Osteoarthritis  Lupus

Fibromyalgia

Other Autoimmune Disorders: \_\_\_\_\_

Acne  Eczema  Psoriasis

Other Skin disorders: \_\_\_\_\_

- Glaucoma                                       Cataracts                                       Vision Deficit
- Hearing Deficit                                       Seasonal Allergies
- Other Ear, Nose, Throat disorders: \_\_\_\_\_

- Headache/Migraine                                       Traumatic Brain Injury                                       Parkinson's Disease
- Alzheimer's/Dementia                                       Seizure Disorder                                       Autism
- Other Neurological disorders: \_\_\_\_\_

- Depression                                       Anxiety                                       Eating Disorder
- Schizophrenia                                       Bipolar                                       ADHD
- Suicide Ideations                                       OCD
- Other Psychiatric disorders: \_\_\_\_\_

- Cancer \_\_\_\_\_

Please identify any other surgeries that you have had in the past:

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Have you had any recent hospitalizations? If so, please list specific hospital with related dates:

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Preventative Screening History (Please Complete If Applicable):

Preventive Screening	Date	Results (If abnormal please explain)	Provider/Facility (if known)
Colonoscopy			
Mammogram (female)			
PAP Smear (female)			
Prostate Screening (male)			
Eye Exam			
Bone Density Scan			

Any other information you would like our team to know:

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Preferred Provider (circle):

Blake Hand, CRNP

Jordan Heath Hammock, CRNP

Jewel Leigh Kirk, CRNP

No preference

Please bring current medication list, including name of medication, dosage, and how often it is taken each day OR bring prescription bottles with you to all Primary Care visits.

I hereby declare that the information provided is true and correct. I also understand that any willful dishonesty may be rendered for refusal of this application.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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TO BE COMPLETED BY FAMILY FIRST PRIMARY CARE, LLC

Approved: \_\_\_\_\_

Appointment date: \_\_\_\_\_ Appointment time: \_\_\_\_\_

Denied: \_\_\_\_\_

Reason for denial:

\_\_\_\_\_

\_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_