WELCOME

Thank you for trusting us with your health care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

A PATIENT INFORMATION

Date 09/13/2021

SS/HIC/Patient ID #

Patient Name Mayersky (Last Name)

Nolan R (First Name) (Middle Initial)

Address 6980 Carolina Pl

City Merrillville

State IN Zip 46410

E-mail n.mayersky@hey.com

Sex ☐ M ☐ F Age Birthdate 07/06/1990

☐ Married ☐ Widowed ☑ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation Software Engineer

Patient Employer/School Self

Employer/School Address

Employer/School Phone (____)

Spouse's Name

Birthdate

SS#

Spouse's Employer

Whom may we thank for referring you?

B INSURANCE

Who is responsible for this account? Me

Relationship to Patient Patient

Birthdate 07/06/1990 SS#

Insurance Co. Anthem

Group # 453467

Is patient covered by additional insurance? ☐ Yes ☑ No

Subscriber's Name

Birthdate SS#

Relationship to Patient

Insurance Co.

Group #

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

Name of Insurance Company(ies)

and assign directly to Dr. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature of Beneficiary, Guardian or Personal Representative

Please print name of Beneficiary, Guardian or Personal Representative

09/13/2021 (Date) (Relationship to Beneficiary)

C PHONE NUMBERS

Home (____)

Cell Phone (____)

Best time and place to reach you Weekday mornings

IN CASE OF EMERGENCY, CONTACT:

Name Peggy Mayersky

Home Phone (____)

Cell Phone (219) 741-3619

Work Phone (____) Ext

D FAMILY HISTORY

Date of last physical examination 05/03/2021

What is your reason for visit? Check up

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☑		☑		☑	
DECEASED	☐	Good	☐	Good	☐	Good
BROTHERS	NO. ALIVE 1	HEALTH Good		NO. DECEASED 0		CAUSE OF DEATH
SISTERS	NO. ALIVE 0	HEALTH		NO. DECEASED 0		CAUSE OF DEATH
CHILDREN	NO. ALIVE 0	AGES & HEALTH		NO. DECEASED 0		AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☑ Diabetes ☑ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis

☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

E MEDICAL HISTORY All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- [x] Chills
- [ ] Depression/Nervousness
- [ ] Dizziness/Fainting
- [x] Fever
- [ ] Forgetfulness
- [ ] Headache
- [x] Loss of sleep
- [x] Loss of weight
- [ ] Numbness
- [ ] Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- [x] Arms
- [ ] Back
- [ ] Feet
- [ ] Hands
- [ ] Hips
- [ ] Legs
- [x] Neck
- [x] Shoulders

GENITO-URINARY
- [ ] Blood in urine
- [ ] Frequent urination
- [ ] Lack of bladder control
- [ ] Painful urination

GASTROINTESTINAL
- [ ] Appetite poor
- [x] Bloating
- [ ] Bowel changes
- [ ] Constipation
- [ ] Diarrhea
- [ ] Excessive thirst
- [x] Gas
- [ ] Hemorrhoids
- [ ] Indigestion
- [x] Nausea
- [ ] Rectal bleeding
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Vomiting blood

CARDIOVASCULAR
- [ ] Chest pain
- [x] High/Low blood pressure
- [x] Irregular/Rapid heart beat
- [ ] Poor circulation
- [ ] Swelling of ankles
- [ ] Varicose veins

EYE, EAR, NOSE, THROAT
- [ ] Bleeding gums
- [x] Blurred vision
- [ ] Crossed eyes
- [ ] Difficulty swallowing
- [ ] Double vision
- [ ] Earache/Ear discharge
- [x] Hay fever
- [x] Hoarseness
- [ ] Loss of hearing
- [x] Nosebleeds
- [ ] Persistent cough
- [ ] Ringing in ears
- [ ] Sinus problems
- [ ] Vision – Flashes/Halos

SKIN
- [x] Bruise easily
- [ ] Hives
- [ ] Itching/Rash
- [ ] Change in moles
- [ ] Scars
- [ ] Sore that won't heal

MEN only
- [ ] Erection difficulties
- [x] Lump in testicles
- [ ] Penis discharge
- [ ] Sore on penis
- [ ] Other

WOMEN only
- [ ] Abnormal Pap Smear
- [ ] Bleeding between periods
- [ ] Breast lump
- [x] Extreme menstrual pain
- [x] Hot flashes
- [ ] Nipple discharge
- [x] Painful intercourse
- [ ] Vaginal discharge
- [ ] Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? No

Are you pregnant? No

Number of children _____

Check (✓) conditions you have or have had in the past.
- [ ] AIDS
- [ ] Appendicitis
- [x] Arthritis
- [ ] Asthma
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Cancer
- [x] Cataracts
- [ ] Chemical Dependency
- [ ] Chicken Pox
- [ ] Diabetes
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Glaucoma
- [x] Heart Disease
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Cholesterol
- [ ] HIV Positive
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Measles
- [ ] Migraine Headaches
- [x] Multiple Sclerosis
- [ ] Mumps
- [x] Pacemaker
- [ ] Pneumonia
- [ ] Polio
- [ ] Prostate Problem
- [ ] Rheumatic Fever
- [ ] Scarlet Fever
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tuberculosis
- [x] Ulcers
- [ ] Venereal Disease

Describe serious illnesses or operations _____

MEDICATIONS/ALLERGIES

List medications you are currently taking None

None

Pharmacy Name CVS

Phone (210) 555-5555

List allergies to medications or substances _____

Amoxicillin

HEALTH HABITS

Check (✓) which you use and how much:
- [x] Caffeine _____
- [ ] Street Drugs _____
- [x] Tobacco _____
- [ ] Other _____

Check (✓) if your work exposes you to:
- [x] Stress
- [ ] Heavy Lifting
- [ ] Hazardous Substances
- [ ] Other _____

Your occupation Software Engineer

F SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ 09/13/2021
Signature of Patient, Parent, Guardian or Personal Representative — Date

Nolan Mayersky — Patient
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

_____ 09/13/2021
Reviewed By — Date