BlessedCare Center, Inc

BLESSEDCARE CENTER, INC

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Phone# 813-304-1299 Fax# 813-304-1423

Practitioner Assessment and Insurance Information

Please complete the following form and bring it with you to your first appointment. Your doctor will need to review your health risk assessment.
You can mail the completed form to us using the Blessedcare center address at the top of this page.

General Information:

_____ _____ ____ _____
Patient last name First name MI DOB

(_____)_____ (_____)_____
Home phone # Cell phone #

_____ _____ _____ _____
Home address City State Zip

_____
SS# Gender F M Single Married Divorce Widowed

_____
Employer

_____ _____
Primary Insurance Carrier Policy ID #

_____ _____ _____ _____
HMO PPO Other Insurance Carrier phone #

_____ _____
Second Insurance Carrier Policy ID #

_____ _____ _____ _____
HMO PPO Other Insurance Carrier phone #

_____

_____

Important: In case of emergency, who would we contact?

_____ _____
Name Relationship

_____ _____
Address (street, City, Zip) Home Phone #

(_____)_____ (_____)_____
Home phone # Cell phone #

"I understand that I am financially responsible for all charges, whether or not paid by said insurance. It is my responsibility to pay any deductible amount due at the time of service or any other balance not paid by my Insurance within 30 days. I authorize disclosure of necessary medical information to determine benefits payable to related services.
By signing this form, I hereby give Blessedcare Center consent to perform medical treatment"

_____ _____
Patient/Gardian Signature Date

Please check ALL conditions that you have:

DIABETES_____ _____
HYPERLIPIDEMIA _____
HYPOTHYROIDISM_____
HEART DISEASE_____
COUGH _____
EMPHYSEMA_____
ASTHMA_____
OTHER LUNG PROBLEMS_____
GASTROINTESTINAL PROBLEMS_____
CIRRHOSIS OF LIVER_____
HEPATITIS_____
CONSTIPATION_____
ARTHRITIS _____
KIDNEY PROBLEMS_____
KIDNEY STONES_____
URINARY LEAKING_____
PARKINSON _____
PROSTATE PROBLEMS_____
DEMENTIA _____
MEMORY PROBLEMS _____
JOINT PROBLEMS _____
MUSCLE PAIN _____
EDEMA _____
EYES PROBLEMS _____
NEUROPATHY _____
WEAKNESS IN BOTH UPPER OR LOWER EXTREMITIES
_____

HEADACHES _____
CANCER _____
LEUKEMIA _____
PLEASE WRITE OTHER MEDICAL PROBLEMS YOU CURRENTLY HAVE

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient last name _____ First name _____ MI ____ DOB _____

Family History	Circle sex	Living	Deceased Cause of death
Father		Age Health	
Mother			
Brother/Sister	M S		
	M S		
	M S		
Husband/wife			
Sons/Daughters	M S		
	M S		
	M S		
	M S		

Check if any blood relative has or had any of the following and enter their relationship:

Condition	**YES**	**NO**	**Relationship to you**
ARTHRITIS			
ASTHMA			
BLEEDING TENDENCY			
CANCER			
COLITIS			
CONGENITAL HEART DZ			
DIABETES			
EMPHYSEMA			
EPILEPSY			
GOITE			
GOUT			
HAY FEVER			
HAERT ATTACK			
HIGH BLOOD PRESSURE			
INTESTINAL POLYPS			
KIDNEY DZ			
LEUKEMIA			
MIGRAINE			
NERVOUS BREAKDOWN			

RHEUMATIC FEVER			
SICKLE CELL ANEMIA			
STROKE			
SUICIDE			
TUBERCULOSIS			
PARKINSON			
DEMENTIA			
ALLERGIES			
OTHER			

ALLERGIES: □ None (Please note reaction for each medication) LATEX ALLERGY □ YES □ NO

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____FOOD ALLERGIES: □ YES □ NO
_____DYES OR TAPE ALLERGIES: □ YES □ NO _____
SHELLFISH OR IODINE ALLERGIES: □ YES □ NO
_____

SURGICAL HISTORY:

□ None Reported Please list surgery and approximate date

_____
_____
_____
_____
_____
_____
_____
Implants / Devices (such Pacemaker, Shunts, joint implants, please list site of implant, ie. – left hip)
_____
_____

_____ _____ ____ _____
Patient last name First name MI DOB

Surgery / Anesthesia-related Problems: □ NONE □ Anesthesia Problems □ Malignant hyperthermia □ □ Family History of anesthesia problems □ Other:
_____

SOCIAL HISTORY: □ Single □ Married □ Divorced □ Widowed
Advanced Directives □ YES □ NO
Occupation: _____
Smoker: □ YES □ NO Quit: _____Packs per day: _____ Number of years smoked:_____
Alcohol: □ YES □ NO Drinks per day/week: _____
Drug Use or Addiction: □ YES □ NO □ Past – Quit: _____
Drug: _____
Is there someone that lives with you in your residence No____ Yes/ Relationship
_____

Type of residence: Apartment ____ House ____ Mobil Home ___ Assisted Living ___,
Name of the ALF _____

Do you use any of the following Medical equipment: Wheelchair ____ Walker _____
Cane_____ Oxygen _____ Nebulizer _____ CPAP/BIPAP _____ Other
_____

Can you afford medicines? YES _____ NO _____

Transportation Provided by: _____

Nutritional History: Weight _____ Height _____ BMI _____ Any weight changes in the past 6 months:
_____
Current diet: Regular Diabetic, weight loss diet, Special diet
Exercise: YES _____ NO _____

ACTIVITIES OF DAILY LIVING and INSTRUMENTAL ADL.

ADLs / IADLs	Requires No Assistance	Some Assistance Needed	Complete Assistanc Needed
Bathing			

Dressing	**Require no assistance**	**Some assistance**	**Complete assistan needed**
Grooming			
Oral Care			
Toileting			
Transferring			
Walking			
Climbing Stairs			
Eating			
Shopping			
Cooking			
Managing Medications			
Uses the Phone			
Housework			
Laundry			
Driving			
Managing Finances			
Totals			

MEDICATIONS:

List each medication; its dosage and how often you take it, including vitamins and other supplements.

MEDICATION	DOSAGE	HOW OFTEN	WHEN STARTED

MEDICATION	DOSAGE	HOW OFTEN	WHEN STARTED

Are you allergy to medication, if yes write its name and the reaction that you have when taking it

MEDICATION	REACTION

Patient last name _____ First name _____ MI ____ DOB _____

PREVENTATIVE SERVICE HISTORY

MEASURE NAME	DATE
A1C	
ANKLE BRACHIAL INDEX	
ARTERIAL DOPPLER LE	
BLOOD GLUCOSE	
BONE DENSITY	
CAROTID DOPPLER	
CHEST X RAY	
CHLAMYDUA SCREENING	
COLONOSCOPY	
DENTAL EXAM	
DILATED EYE EXAM	
DTaP VACCINE (90700)	
ECHOCARDIOGRAM	
EKG	
FLEXIBLE SIGMOIDOSCOPY	
FLU VACCINE	
FLU VACCINE OFFERED & REFUSED	
FOOT EXAM	
HIV TEST	
LIPIDS	
HPV TEST	
HPV VACCINE	
LAST COMPLETE PHYSICAL	
MAMOGRAPHY	
PAP SMEAR	
PNEUMOVAX VACCINE	
PREVNAR 13	
PNEUMONIA VACCINE OFFERED AND REFUSED	
PSA	
PULMONARY FUNCTION TESTS	
ROUTINE EYE EXAM	
STOOL OCCULT BLOOD	
STRESS TEST	
Td Vaccine	
Tdap Vaccine Adult	

TUBERCULINE PPD	
Other vaccines	
URINE MICROALBUMINURIA	
VARICELLA	
ZOSTER VACCINE (90736)	
CATARACT SURGERY	
BARIUM ENEMA	

Date reviewed Physician Signature