CENTERVILLE MEDICAL CENTER
DBA CHUKWUMA OSUAGWU MD PA
1015 W. Centerville Rd. Ste. 118 Garland, TX 75041
Office (972) 807-6016 Fax (972) 807-6035

NEW PATIENT INFORMATION

Today's Date_____

☐ MR. ☐ MS. ☐ MRS. ☐ DR. **LAST NAME** **FIRST** **MIDDLE**

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORSED ☐ WIDOWED

SOCIAL SECURITY # DATE OF BIRTH SPOUSE NAME

HOME ADDRESS APT# CITY STATE ZIP

HOME PHONE # CELL # WORK # EMAIL

EMPLOYER CITY STATE ZIP

EMERGENCY CONTACT PERSON(S) EMERG. CONTACT #

PREFERRED COMMUNICATION METHOD: ☐ HOME # ☐ CELL # ☐ WORK # ☐ EMAIL ☐ MAIL ☐ DECLINE ☐ OTHER

GUARANTOR INFORMATION (Person responsible for payment of Bill)

NAME RELATIONSHIP DATE OF BIRTH SS#

HOME ADDRESS APT # CITY STATE ZIP

EMPLOYER CITY STATE ZIP

OCCUPATION CELL # WORK # EMAIL

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURED NAME:		
INSURANCE COMPANY:		
POLICY #:		
GROUP NAME:		
GROUP #:		

IF THE PERSON INSURED IS DIFFERENT FROM THE GUARANTOR, PLEASE PROVIDE THE INFORMATION BELOW, SO WE CAN ASSIST YOU IN FILING YOUR MEDICAL CLAIM

NAME RELATIONSHIP DOB SS #

HOME ADDRESS APT # CITY STATE ZIP

EMPLOYER CITY STATE ZIP

OCCUPATION CELL # WORK # EMAIL

☐ **I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. I RELEASE YOU FROM LL LEGAL RESPONSIBILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED.**

☐ **I DO NOT AUTHORIZE YOU TO RELEASE ANY INFORMATION ACQUIRED IN MY EXAMINATION OR TREATMENT NECESSARY TO PROCESS MY INSURANCE CLAIMS. IN DOING SO, I AM RESPONSIBLE FOR MY MEDICAL BILLS.**

Signature of Patient/Legally Authorized Representative _____ Relationship _____ Date _____

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PATIENT HEALTH HISTORY

PATIENT NAME: _____ DATE OF BIRTH: ____/____/_____ AGE: _____ ☐ MALE ☐ FEMALE

HOME PHONE: _____ WORK: _____

RETAIL PHARMACY: _____ PHONE: _____

MAIL ORDER PHARMACY: _____ PHONE: _____

REASONS FOR THIS VISIT: _____

PLEASE LIST THE NAMES OF ALL PHYSICIANS YOU CURRENTLY SEE:

1. _____ 3. _____

2. _____ 4. _____

MEDICATIONS: (LIST ALL MEDICATIONS, INCLUDING DOSE AND HOW OFTEN YOU TAKE IT)

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

PLEASE LIS ALL OVER THE COUNTER MEDICATIONS (EXAMPLES: Tylenol, Advil…), HERBAL SUPPLEMENTS AND VITAMINS YOU CURRENTLY TAKE.

1. _____ 3. _____

2. _____ 4. _____

ALERGIES: _____

PREVIOUS MEDICAL HISTORY

DO YOU SUFFER FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS?					CHECK IF ANY OF YOUR BLOOD RELATIVES HAD ANY OF THE FOLLOWING:					**RELATIONSHIP TO YOU:**
HIGH BLOOD PRESSURE	☐	YES	☐	NO	HIGH BLOOD PRESSURE	☐	YES	☐	NO	
HEART DISEASE	☐	YES	☐	NO	HEART DISEASE	☐	YES	☐	NO	
STROKE	☐	YES	☐	NO	STROKE	☐	YES	☐	NO	
DIABETES	☐	YES	☐	NO	DIABETES	☐	YES	☐	NO	
ASTHMA	☐	YES	☐	NO	ASTHMA	☐	YES	☐	NO	
MALIGNANCY/CANCER	☐	YES	☐	NO	MALIGNANCY/CANCER	☐	YES	☐	NO	
SEIZURES	☐	YES	☐	NO	SEIZURES	☐	YES	☐	NO	

DO YOU SMOKE? ☐ YES ☐ NO HOW OFTEN? _____

DO YOU USE ALCOHOL OFTEN? ☐ YES ☐ NO HOW OFTEN? _____

FOR FEMALE PATIENTS ONLY: DATE OF YOUR LAST MENTRUAL CYCLE? _____

LIST ANY SURGERIES: _____

LIST OTHER ILLNESSES: _____