

Mid-America Diabetes Associates, PA

200 S Hillside, Wichita KS 67211

Medical and Family History

Name (Last, First, Middle Initial)	Date of Birth	DATE:
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Your Occupation	Education (Circle highest level received)	Grade School	Junior High
	High School (1 2 3 4)	College (1 2 3 4)	Graduate School

List other people living at your residence and their ages: _____

Personal and Family Medical History (parents, children, grandparents, brothers and sisters)

Disease(s)	Self (Diagnosis Date)	Current Problem		Physician Treating Condition?	Family Member Relationship with this condition?
		Yes	No		
<i>EX (Arthritis)</i>	<i>2006</i>	<i>X</i>		<i>Dr Hand</i>	<i>Dad, sister</i>
Arthritis					
Asthma					
COPD					
Diabetes					
Heart Disease					
Stroke/TIA					
High Blood Pressure					
Cholesterol/Triglycerides					
Congestive Heart Failure					
Sleep Apnea					
Anemia					
Cancer (list location)					
Emotional/Depression or other Psychiatric diagnosis					
Thyroid Disease					
Retinopathy/Cataracts/ macular changes					
Kidney Disease					
Neuropathy-nerve pain					
Foot ulcers					
Gastroparesis					
Gastric Reflux					
Celiac Disease					
Alcohol/Drug Abuse					
Other (list)					

Allergies (explain): None Hay Fever/Seasonal Other _____

Foods: _____

Medications: _____

If applicable, please list your children and their birth weights: _____

Surgeries/Hospitalizations: _____

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PATIENT INFORMATION

Name (Last, First, Middle Initial)		Birthdate:		Today's Date:	
Address		City		State	
Email		Home Phone		Cell Phone	
Marital Status: <input type="checkbox"/> Child <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		Spouse Name		Parents' Name (if applicable)	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> White					
Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other(list)					
Emergency Contact		Emergency Contact Phone Number		Relationship to patient	
Other Family Members Seen here					

Primary Care Physician/Provider (list city/state where located)	Referring Physician (list city/state where located)
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INSURED'S BILLING INFORMATION

Subscriber's Name (Last, First, Middle Initial)		Relationship to Patient			
Address		City		State	
Subscriber's Date of Birth		Subscriber's Social Security No		Patient's Social Security No	
Employer		Occupation		Work Phone	

MEDICAL INSURANCE INFORMATION (Please present insurance card to receptionist)

<i>Primary Insurance</i>		Insurance Company Name			
Insurance Company Address		Policy Number		Group Number	
<i>Secondary Insurance</i>		Insurance Company Name			
Insurance Company Address		Policy Number		Group Number	

Patient's or Authorized Person's Signature I authorize the release of any medical or other information necessary to process my medical claims . I also request payment of government benefits either to myself or Mid-America Diabetes Associates, PA who accepts assignment.

X

Insured's or Authorized Person's Signature I authorize payment of medical benefits to Mid-America Diabetes Associates, PA for services received.

X