Timothy Cassidy APRN FNP-C
263 SW Professional Glen
Lake City, FL 32025
(PH) 386-438-5722 (FX) 386-438-8631

PATIENT INFORMATION:

Last Name: _____ First Name: _____ M.I._____
Address: _____
Home Phone: _____ Work Phone: _____
Social Security #: _____ DOB: _____ Age: _____
Sexual Orientation: _____ Sex: _____
Employer: _____ Occupation: _____

Emergency Contact:
Name: _____ Phone number: _____

INSURANCE INFORMATION:
Insurance Carrier: _____
Address: _____
ID # _____ Group # _____
Phone # _____

Primary policy holder name:
Name: _____ Relationship to Patient: _____
Address: _____
Phone: _____ DOB: _____ Sex: _____
SS#_____

GUARANTOR INFORMATION: Complete this section only if patient is not responsible for this account
Name: _____
Address:_____
Phone:_____ SS#:_____

I request that payment of authorized insurance benefits be made on my behalf to the Timothy Cassidy for any services furnished me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether covered by insurance.

Patient's/Guarantor's Signature: _____
Date: _____

ADDITIONAL INFORMATION:

Were you injured on the job?

◯ Yes ◯ No Date: _____

Were you injured in an automobile accident?

◯ Yes ◯ No Date: _____

When did you first consult us for this condition? Date: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. (INCLUDE DOSE AND HOW OFTEN)

Pharmacy_____

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

PAST MEDICAL HISTORY

1. SURGICAL HISTORY (list type/approximate date):
2. ANY SERIOUS INJURIES (list type/approximate date):
3. OTHER HOSPITALIZATIONS (give reason/approximate date):
4. ALLERGIES: _____

SOCIAL HISTORY

Do you smoke? ◯ Yes ◯ No

If so, how much and type of tobacco per day? _____ #Years _____

Do you drink? ◯ Yes ◯ No

If so, how much and type of alcohol per day? _____ # Years _____

Any Illicit Drug Use? ◯ Yes ◯ No

If so, Type/ Frequency? _____ # Years _____

PLEASE CHECK ANY OF THE FOLLOWING ILLNESSES YOU HAVE HAD:

- ☐ Chronic skin condition
- ☐ Chest pain
- ☐ Heartburn
- ☐ Heart problems
- ☐ Hypertension
- ☐ Glaucoma
- ☐ Palpitations
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Hearing problems
- ☐ Headaches
- ☐ Paralysis
- ☐ Difficulty urinating
- ☐ Stroke
- ☐ Dizziness
- ☐ Thyroid issues
- ☐ Prostate issues
- ☐ Diabetes Leg
- ☐ Cramps
- ☐ Hepatitis
- ☐ Shortness of
- ☐ Breath Anemia
- ☐ Seizures
- ☐ Hypertension
- ☐ COPD
- ☐ Arthritis
- ☐ Cancer
- ☐ Cirrhosis
- ☐ Asthma
- ☐ GI bleed
- ☐ Depression
- ☐ Circulation problems
- ☐ Upper GI
- ☐ Colonoscopy
- ☐ Stress Test
- ☐ Pap Smear
- ☐ Mammogram

FAMILY MEDICAL HISTORY (please list any health problems/cause of death)

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Social History (check all that apply):

Eat healthy ☐
Exercise Regularly ☐
Household has smoke detector ☐
Wears Seatbelts ☐
Married ☐

Vaccines: (date)

Flu	◯ Yes	◯ No
Pneumococcal	◯ Yes	◯ No
Tetanus	◯ Yes	◯ No
Covid 19	◯ Yes	◯ No

Briefly describe the medical problems bothering you the most: