Atlantic Adult And Pediatric Medicine
34435 King Street Row, Suite 1
Lewes, DE 19958
Phone: 302-644-1300 Fax: 302-644-1086

Welcome to Atlantic Adult and Pediatric Medicine. We are pleased that you have chosen us to be your primary care provider. Enclosed you will find our New Patient Packet.

In order for us to schedule an appointment, we need you to thoroughly complete the enclosed packet and return to us via mail, fax, e-mail or you may drop it off at our office. It is VERY IMPORTANT that the medical history forms be completed in full.

If you are transferring your healthcare from another provider or facility to our office, you may contact the physician or facility to have them transfer your records to us. However, for your convenience there is a “Release of Medical Records” form that you may complete. If you would like for us to request your records, please complete this form in its entirety. *Please note: for children ages 18 and under - we **MUST** have immunization records prior to their appointment.

As a new patient, please arrive 15 minutes prior to your scheduled appointment time with this paperwork completed. Bring your insurance card, photo ID and all medications in their original containers. Co-pays are due at the time of service. If you do not have insurance, you will be responsible for payment in full at the time of your visit.

Thank you again for choosing Atlantic Adult and Pediatric Medicine, We look forward to serving your healthcare needs.

Atlantic Adult and Pediatric Medicine
Confidential Contact Form

Last Name:_____First Name:_____Middle Initial:_____
Age:_____Date of Birth:_____Social Security #:_____
Address:_____City:_____State:_____Zip:_____
Telephone: (H)_____ (W)_____(Cell)_____
Email Address:_____Gender: Female_____Male_____
Occupation:_____ (circle) Full Time / Part Time / Student / Retired
Emergency Contact:_____ Relationship:_____
Emergency Contact Number: (H)_____(W)_____(Cell)_____

INSURANCE
Please provide a copy of the front and back of your insurance card(s).
Subcribers Name (if different):_____
Subcribers Date of Birth:_____/_____/_____ Relationship to patient:_____
Subcribers Address: (if different from above)_____City_____State____Zip____
Insurance Company:_____
Address of Insurance plan:_____Phone:_____
Claims Address:_____City_____State_____Zip:_____
Claims Phone:_____Group #_____
Member/Policy #_____
Do you have any secondary or additional Insurance plans? YES NO
Secondary Insurance Company:_____
Subcribers Name (if different):_____
Subcribers Date of Birth:_____/_____/_____ Relationship to patient:_____
Subcribers Address: (if different from above)_____City_____State____Zip____
Address of Secondary plan:_____Phone:_____
Claims Address:_____City_____State_____Zip:_____
Claims Phone:_____Group #_____
Member/Policy ID #_____

By signing below, I verify that the above information is correct and true to the best of my knowledge.

Signature:_____Date:_____

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Patient Health Information Packet

Patient Name: _____ Date: _____
Date of Birth: _____/____/____

Name(s) of other doctors you see and why_____

_____

Name and locations of pharmacy you use _____

CURRENT ACTIVE PROBLEM:

What is the reason for your visit today _____?

CURRENT MEDICAL HISTORY:

These are conditions you are currently being treated for. Please check all that apply.

___Coronary Artery Disease
___COPD or Emphysema
___Asthma
___Elevated Cholesterol
___High Blood Pressure
___Stroke
___Blood Clots
___Respiratory Problems
___Head Injury
___MRSA
___Kidney Problems (Like stones or infection)
___Liver Disease/Hepatitis
___Bleeding Disorder
___Thyroid Problems
___Seizure Disorder
___Fainting Spells
___Depression, Anxiety, or other psychological issues
___Diabetes – Need Insulin Y/N
___Pregnant
___HIV/Aids
___Cancer – If yes, what type? _____

List any other problems you are currently being treated for that are not listed above.

_____

_____

PAST MEDICAL HISTORY

These are conditions you have been treated for in the past but are not currently being treated for. Please check all that apply.

___Heart Attack
___Elevated Cholesterol
___High Blood Pressure
___Stroke
___Blood Clots
___Problems in Pregnancy
___Respiratory Problems
___Asthma
___Headaches/Migraines
___MRSA
___Genetic Disorders
___Kidney Problems (like stones or infection)
___Liver Disease/Hepatitis
___Bleeding Disorder
___Thyroid Disorder
___Seizure Disorder
___Fainting Spells
___Depression, Anxiety, other psychological issues
___Diabetes – Needed Insulin Y / N
___HIV/AIDS
___Pregnancy Complications
___Osteoporosis
___Cancer – If yes what type? _____

STD (Please circle) Chlamydia, Gonorrhea, Herpes, Syphilis, Abnormal pap

PAST MEDICAL HISTORY (CONTINUED)

List all Health Maintenance studies/procedures you have had in the past 5 years and year performed: (PAP, Mammogram, EKG, Colonoscopy, etc.)_____
_____
_____

HOSPITALIZATIONS: If you have ever been hospitalized for any serious medical illness or operation, please list below:

YEAR **REASON FOR HOSPITALIZATION**

1. _____
2. _____
3. _____
4. _____

SURGICAL HISTORY

List all surgeries with dates:

PROCEDURE **DATE** **CITY**

1. _____
2. _____
3. _____
4. _____

Have you ever had problems with anesthesia? Yes___ No___
If yes, what problems? _____

FAMILY HISTORY

Please check all that apply. Family includes your parents, children, siblings, aunts and uncles related by blood.

___ Coronary Artery Disease
___Heart Attack
___Elevated Cholesterol
___High Blood Pressure
___Stroke
___Blood Clots
___COPD
___Respiratory Problems
___Asthma
___Genetic Disorders
___Cancer – If yes, what type? _____
___Kidney Problems
___Liver Disease
___Bleeding Disorder
___Thyroid Problems
___Seizure Disorder
___Fainting Spells
___Depression, Anxiety, or other Psychiatric Issues
___Diabetes

List other medical problems that are in your family that are not listed above:
_____
_____

SOCIAL HISTORY

Marital Status: ___Single ___Married ___Widowed ___Divorced ___Separated

Sports or extracurricular activities _____

Tobacco Use or exposure? If so, describe, _____
Do you drink alcohol? Yes/No
How much per week _____
Do you use drugs? (Marijuana, cocaine, narcotics, etc.) Yes/No
Have you been treated for drug or alcohol dependence? Yes/No
Occupation _____ Currently employed: Yes/No
Household members_____
Pets_____

ALLERGIES

Please list all known allergies to drug, food, or other allergen and type of reaction

Drug/Allergen Reaction

_____
_____
_____

MEDICATIONS

List **ALL** medications you take: (use back of paper if you need more room)

Name of Medication Dosage Frequency How long you been taking?

_____
_____
_____
_____
_____
_____

Are you taking any medicines that contain aspirin or anti-inflammatory medicines, such as Bufferin, Goody Powders, Motrin, Ibuprofen, Aleve, Excedrin? Yes / No
If yes, which one(s) _____
Do you take any vitamins, supplements, or over the counter medicines? Yes / No
If yes, which one(s)? _____

Patient Sign and Date

_____