Dear Patient,

Please read all of this information carefully and complete the appropriate forms prior to your appointment. All Family Medicine Associates of Midland forms are on our web site at fma555.net under the FORMS menu. If you have not seen us for awhile, please download and complete an Insurance Update form and a Patient History Update form.

The following two page New Patient form MUST be completed before your appointment. If the form is not completed, your appointment could be delayed.

Payment is expected at the time of service. We accept VISA, MasterCard, American Express and Discover, checks and/or cash for your convenience. Please do not ask us to bill you, or wait for insurance reimbursement from plans we do not participate in. Copays, deductibles and non-covered services are due at the time of service for insurance plans we do not participate in.

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There is a $25.00 charge to patients who miss their scheduled appointment without canceling at least 24 hours prior. Your insurance will NOT cover this charge. It will be billed directly to you and payment is expected prior to your next scheduled appointment. If you miss more than three appointments, you and your family may risk being terminated from the practice. Remember, there is another patient who is unable to see his/her doctor because of your failure to keep your appointment. Please be courteous.

MEDICARE PATIENTS: Medicare does not pay for routine annual exams. They do pay only for the Pap/breast portion of the exam once every two years. You will be responsible for the non-covered portion of your annual exam. If you have questions, please feel free to call 989-631-9515 between the hours of 7 a.m. and 2:30 p.m.

Thank you,

Family Medicine Associates of Midland
Family Medicine Associates of Coleman

FMA New Patient Form

PLEASE PRINT (Circle answers)

Patient Name	**Birthdate**	**Age**	**SS Number**

Reason for today's visit.____________________

Describe the following: Severity. Mild Moderate Very

Location of problem____________________How long? ____________________

Cause of problem.____________________Related issues. ____________________

I have reviewed the above information with the patient: Yes No

Provider Comments.____________________

Previous Hospitalizations/Surgeries/Serious Injuries Date

____________________ __________

____________________ __________

____________________ __________

____________________ __________

List all allergies here please.

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Patient Social History

Marital Status	Single	Married	Separated	Divorced	Widowed
Alcohol	Never	Rarely	Moderate	Daily	
Tobacco	Never	Quit	Current packs per day #_________		
Drugs	Never	Type/Frequency ____________________			
Exposure to	Fumes	Dust	Solvents	Noise	

Diseases

Cancer	Yes	No	Arthritis/Gout	Yes	No	Acute Infections	Yes	No
Diabetes	Yes	No	Bleeding	Yes	No	Hereditary Defects	Yes	No
Heart.	Yes	No	Hypertension.	Yes	No	Venereal Disease	Yes	No
Stroke	Yes	No	Convulsions	Yes	No			

Family Medical History:

	Age	**Diseases**	**Cause of Death**
Father	____	____________________	____________________
Mother	____	____________________	____________________
Siblings	____	____________________	____________________
Spouse	____	____________________	____________________
Children	____	____________________	____________________

____________________ __________

Patient Signature (parent/guardian if minor) **Date**

FMA New Patient Form/Medical History (Page 2)

Have you recently experienced any of the following? **Please answer all the questions by circling your answers.**

CONSTITUTIONAL			Date
Good general health lately	No	Yes	______
Recent weight change	No	Yes	______
Fever	No	Yes	______
Fatigue	No	Yes	______
Headaches	No	Yes	______

EYES			
Eye disease or injury	No	Yes	______
Wear glasses/contact lens	No	Yes	______
Blurred or double vision	No	Yes	______
Glaucoma	No	Yes	______

ENT			
Hearing loss	No	Yes	______
Ringing in the ears	No	Yes	______
Earaches or drainage	No	Yes	______
Sinus problems	No	Yes	______
Nose bleeds	No	Yes	______
Mouth sores	No	Yes	______
Bleedinggums	No	Yes	______
Bad breath or bad taste	No	Yes	______
Sore throat or voice change	No	Yes	______
Swollen glands in neck	No	Yes	______

CARDIOVASCULAR			
Heart trouble	No	Yes	______
Chest pains	No	Yes	______
Sudden heart beat changes	No	Yes	______
Swelling of feet, ankles or hands	No	Yes	______

RESPIRATORY			
Frequent coughing	No	Yes	______
Spitting up blood	No	Yes	______
Shortness of breath	No	Yes	______
Asthma or wheezing	No	Yes	______

GASTROINTESTINAL			
Loss of appetite	No	Yes	______
Change in bowel movements	No	Yes	______
Nausea orvomiting	No	Yes	______
Frequent diarrhea	No	Yes	______
Painful BM or constipation	No	Yes	______
Blood in stool	No	Yes	______
Stomach pain	No	Yes	______

GENITOURINARY			
Frequent urination	No	Yes	______
Burning or painful urination	No	Yes	______
Blood in urine	No	Yes	______
Change of force/strain urinating	No	Yes	______
Incontinence or dribbling	No	Yes	______
Kidney stones	No	Yes	______
Testicle pain	No	Yes	______
Female - Pain with periods	No	Yes	______
Irregular periods	No	Yes	______
Vaginal discharge	No	Yes	______

Pregnancies #___ Miscarriages # ___

Date last Pap Smear______________

Findings Normal Abnormal

MUSCULOSKELETAL			Date
Joint pain	No	Yes	______
Joint stiffuess or swelling	No	Yes	______
Weakness ofmuscles or joints	No	Yes	______
Muscle pain or cramps	No	Yes	______
Back pain	No	Yes	______
Cold extremities	No	Yes	______
Difficulty in walking	No	Yes	______

SKIN			
Rash or itching	No	Yes	______
Change in skin color	No	Yes	______
Change in hair or nails	No	Yes	______
Varicose veins	No	Yes	______
Breast pain	No	Yes	______
Breast lump	No	Yes	______
Breast discharge	No	Yes	______

NEUROLOGICAL			
Frequent or recurring headaches	No	Yes	______
Light headed or dizzy	No	Yes	______
Convulsions or seizures	No	Yes	______
Numbness or tingling sensations	No	Yes	______
Tremors	No	Yes	______
Paralysis	No	Yes	______
Stroke	No	Yes	______

PSYCHIATRIC			
Memory loss or confusion	No	Yes	______
Nervousness	No	Yes	______
Depression	No	Yes	______
Sleep problems	No	Yes	______

ENDOCRINE			
Frequent coughing	No	Yes	______
Spitting up blood	No	Yes	______
Shortness of breath	No	Yes	______
Asthma or wheezing	No	Yes	______

HEMATOLOGIC/LYMPHATIC			
Loss of appetite	No	Yes	______
Change in bowel movements	No	Yes	______
Nausea or vomiting	No	Yes	______
Frequent diarrhea	No	Yes	______
Painful BM or constipation	No	Yes	______
Blood in stool	No	Yes	______
Stomach pain	No	Yes	______

List all medications you are now taking.

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____

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____

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____ ________________________

Provider Signature (I have reviewed both pages of the New Patient Form) **Date**