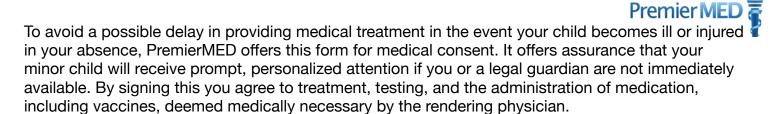


PREMIERMED FAMILY AND SPORTS MEDICINE Minor Annual Wellness Visit Form 2022

(Please do not leave any field blank; if something does not apply, write "N/A". If unknown, write "unknown")

Patient First/Las	t Name:			
			curity #:	
Mailing Address:				
Oity:		State:	Zip Code:	
			dary Phone:	
Email Address: _				
Marital Status:	□Single □Ma	arried Divorce	d □Widowed □Separated	
Sex: □Male □Fe	emale Gend	er:	Pronouns:	
			□ □American Indian or Alaska Native □Asi	ian
□Native Hawaiia				
Ethnicity: □Hispa	anic/Latino @	DNot Hispanic/L	_atino □Decline	
discussions and de PremierMED Fami following individual Contact First/Las Relation:	ecisions relatily & Sport Meals. st Name:	ed to my medical edicine and/or sta	act Number:	sion for ation to the
Mailing Address:			Zip Code:	
Jily		State		
INSURANCE				
nsurance:				_
Policy Number: ₋			Group Number:	
Policy Holder:			Relation to Patient: der SSN:	
Date of Birth:	//	Policy Hold	ler SSN:	
Secondary Insur	ance:			
Policy Number:			Group Number:	
Policy Holder:			Relation to Patient:	<u> </u>
Date of Birth:	_//_	Policy Hold	der SSN:	
		OFFIC	CE USE ONLY	
	SCANNED F		_ SCANNED INSURANCE CARD: IEWED BY:	
		, I OI !!VIO I !L V !!		

Parental Consent for Medical Treatment of a Minor



Patient First/Last Name:	Date of Birth: _	/_	/	/	_

CURRENT MEDICATIONS (Leave blank if not currently taking medications)



1	5
2	6
3	
4	8
ALLERGIES/MEDICATION S	IDE EFFECTS (Please list the agent/medication and reaction)
Parent / guardian 1:	
Name:	Relation:
Phone:	Secondary Phone:
Home Address:	
Devent / guardian Or	
Parent / guardian 2:	D. L. C.
	Relation:
	Secondary Phone:
Home Address:	
Other caregiver:	
· ·	Relation:
THORE.	Date of Birth/
medical diagnosis, etc. to be r	ize the above adult caregiver to consent to any necessary examination rendered to the above-named minor child under the general of a PremierMED licensed physician. Additionally, I agree to pay for a in my absence.
Signature of Parent / Guardian	n: Date:
3	
You may amend this cons	ent in writing at any time. Otherwise, this consent form does not
	expire.
	ve blank if no past/current medical history)
1	6
2	7
3	8
4	9
5	10
SIIDGICAI LISTODY // >	ave blank if no surgical history)
1	3
C .	☆ .

	(8)
Premier MED	1
	1

5	8
0	9
6 7	10
Do you currently see any specialists? (Please li	ist the name, specialty, and location.)
Do you need any referrals today? If so, please for the referral. If you have the provider picked	state the type of specialist and the reasoning
SOCIAL HISTORY Occupation: Employers	
Who lives with you? □Spouse/Partner □Children □Roommates □F	Parents □Other
Tobacco use (including cigars/vape/smokeless Current everyday Current someday Former	
Alcohol use (beer/wine/liquor): 1-3 -4-6 -7+ per -Day -Week -Month -	¹Year □No alcohol use
FEMALES Currently menstruating: Date of last menstruat Normal cycles Date of last menstruat No longer menstruating: Natural menopause Hysterectomy Date Are you breastfeeding or pregnant? Yes No	olain:
Are you using any type of birth control? If yes, what kind and when did you start using If not, are you interested in discussing birth cor Date of last PAP smear://	ntrol options during your visit? □Yes □No

MALES



Date of last prostate exam:		
Have you noticed any testicular p	oain or lumps/bumps? □Yes □No	
If so, location	how long as this been present?_	
Last DEXA scan://	ologuard □FOBT:// Performing provider: // Performing provider: _	
Do you eat a well-balanced diet?		
_	etary restrictions?	
VACCINATIONS Shingles	⁻ dap) □Yes □No	
Are you interested in receiving ar	ny vaccines during today's visit? □Yes	s □No
FAMILY HISTORY Father: □Living □Deceased History of: □High blood pressure Other	□Diabetes □ Cancer, type:	_ □Stroke
Mother: □Living □Deceased History of: □High blood pressure Other	□Diabetes □ Cancer, type:	_ □Stroke
Other significant family history: _		
PREFERRED PHARMACY Name: Address:	Phone:	
City:	State: Zin Code:	