

PATIENT INFORMATION

Last name	First name	MI
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Street address	City	State	ZIP
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Date of birth	Age	Sex	Email
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Home phone	Cell phone	Work phone
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You may leave voice or text messages containing health information at: ☐ Home ☐ Cell ☐ Work

Emergency contact	Relationship	Phone
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Occupation	Preferred language	Social Security #
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Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment ☐ Full time ☐ Part time ☐ Retired ☐ Student ☐ Not employed

The following is collected to meet federal reporting requirements under the American Recovery and Reinvestment Act of 2009. You may decline any item.

Ethnicity ☐ Hispanic or Latino/a ☐ Non-Hispanic ☐ Decline to answer

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White ☐ Other ☐ Decline to answer

PREFERRED PHARMACY

Pharmacy name	Phone	Cross streets
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INSURANCE

Primary

Insurance company	Policyholder name
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Policyholder date of birth	Relationship to patient
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Secondary (if applicable)

Insurance company	Policyholder name
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Policyholder date of birth	Relationship to patient
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Person responsible for financial statements ☐ Patient ☐ Someone else (complete below)

Last name	First name	MI
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Street address	City	State	ZIP
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Date of birth	Phone	Email
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PHYSICIANS

Primary care physician	Practice / location	Phone	Fax
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Cardiologist	Practice / location	Phone	Fax
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Referring physician	Practice / location	Phone	Fax
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MEDICAL HISTORY

Mark anything you have had. If nothing in a row applies, check None.

Cardiovascular ☐ Heart disease ☐ Stroke ☐ Heart attack ☐ High blood pressure ☐ High cholesterol ☐ Chest discomfort
☐ Angina ☐ Palpitations ☐ Arrhythmia ☐ Atrial fibrillation ☐ Congestive heart failure ☐ Coronary artery disease
☐ Swelling in feet or ankles ☐ None

Vascular ☐ DVT ☐ Peripheral artery disease ☐ Thoracic or abdominal aneurysm ☐ None

Endocrine ☐ Diabetes ☐ Thyroid disease ☐ Autoimmune disorder ☐ Kidney disease ☐ None

Musculoskeletal ☐ Arthritis ☐ Osteoporosis ☐ Chronic back pain ☐ Joint pain ☐ Muscle weakness ☐ None

Neurological ☐ Neurological disease ☐ Epilepsy ☐ Chronic headaches ☐ Numbness or tingling ☐ Alzheimer's or dementia
☐ Multiple sclerosis ☐ Memory loss ☐ None

Respiratory ☐ Asthma ☐ COPD ☐ Shortness of breath ☐ Sleep apnea ☐ None

Hematology ☐ Anemia ☐ Bleeding disorder ☐ Factor V ☐ None

Infectious disease ☐ HIV ☐ Hepatitis ☐ C-diff ☐ None

Skin ☐ Edema ☐ Ulcers ☐ Gangrene ☐ Blue or discoloured skin ☐ None

Psychiatric ☐ Anxiety ☐ Depression ☐ None

Cancer - type

Treatment received

SURGICAL HISTORY

Mark anything you have had. If nothing in a row applies, check None.

Cardiac ☐ Heart bypass ☐ Heart stents ☐ Pacemaker ☐ Cardioversion ☐ Mitral valve replacement ☐ None

Vascular ☐ Carotid surgery ☐ Aneurysm surgery ☐ Angioplasty or stents ☐ Amputation ☐ Vein ablation ☐ None

Gastrointestinal ☐ GI surgery ☐ Ulcer surgery ☐ Appendectomy ☐ Colectomy ☐ Hernia repair ☐ None

Musculoskeletal ☐ Orthopedic surgery ☐ Back surgery ☐ Shoulder surgery ☐ Knee surgery ☐ Foot surgery ☐ None

Genitourinary ☐ GU surgery ☐ Renal surgery ☐ Prostate surgery ☐ Vasectomy ☐ None

Gynecologic ☐ Hysterectomy ☐ Lumpectomy or mastectomy ☐ None

Other surgeries and approximate dates

FAMILY HISTORY

Mark any condition a blood relative has had.

Relatives ☐ Blood clots (DVT or PE) ☐ Aneurysm ☐ Bleeding or clotting disorder ☐ Stroke ☐ Heart disease ☐ Diabetes
☐ Kidney disease ☐ Cancer

☐ None known

If marked, which relative(s)

SOCIAL HISTORY

Do you smoke cigarettes or vape? ☐ No ☐ Yes

If yes - packs per day or week

Age started

Age stopped

Cigarettes per day

Do you drink alcohol? ☐ No ☐ Yes

If yes, how often? ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

Drinks per occasion

Do you use recreational drugs? ☐ No ☐ Yes

If yes - type and frequency

MEDICATIONS AND ALLERGIES

Are you currently taking aspirin? ☐ No ☐ Yes Are you allergic to IV contrast or iodine? ☐ No ☐ Yes

List all medications you take routinely, including current and previous chemotherapy.

Medication	Dose	How often

Medication allergies and reactions

Other allergies and reactions

ADVANCE DIRECTIVE AND POWER OF ATTORNEY

Do you have an advance medical directive? ☐ No ☐ Yes If yes, have you given us a copy? ☐ No ☐ Yes

Do you have a medical power of attorney? ☐ No ☐ Yes

If yes - name

Phone

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize True Precision Medical to release health/medical information of:

Patient's Full name: _____ Date of Birth: _____

This information may be released to:

Recipient Name: _____ **Relationship to Patient:** _____

Phone Number: _____

Recipient Name: _____ **Relationship to Patient:** _____

Phone Number: _____

Recipient Name: _____ **Relationship to Patient:** _____

Phone Number: _____

I understand that the information I have agreed to release to the aforementioned party/parties may include sensitive clinical information obtained during the dates listed below. These may or may not include treatment of substances or other abuse, HIV, psychiatric disorders, sexually transmitted diseases etc., unless herein except:

This release includes all documents created by True Precision Medical, such as but not limited to:

- *Office, Chart & Progress Notes

- *Ultrasound Reports

- *All documents that True Precision Medical has ordered on your behalf

Covering records dated from:

- *The date of its creation by True Precision Medical, whether in the past or future

I authorize the records to be released to the names listed above as well as:

My emergency contact ☐ YES ☐ NO

My physicians previously listed ☐ YES ☐ NO

I UNDERSTAND THIS AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME. THIS AUTHORIZATION SHALL REMAIN IN EFFECT UNLESS OTHERWISE REVOKED.

Signature (person authorizing release) _____

Date of signature: _____ Relationship to patient: _____

INSURANCE AND PAYMENTS

Financial Responsibility: Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all medical services provided to you. Any charges not paid by your insurance carrier will be your responsibility, except as limited by our specific agreement with your insurance carrier, if such an agreement is in place. If you do not have health insurance, or if your health insurance will not pay for services rendered by us, or if you notify us not to contact or bill your insurance company, you are considered a self-pay patient. Your charges will be based on our current self-pay fee schedule (available at our front desk). Payment is due in full at the time of service.

ACKNOWLEDGEMENTS

Please initial each item. A copy of every document named below is at the front desk and on our website, and is yours to keep.

Notice of Privacy Practices. I have received a copy of True Precision Medical's Notice of Privacy Practices, effective September 30, 2026, which describes how my health information may be used and shared and my rights regarding that information. trueprecisionmedical.com/privacy-practices	Initial: _____
Patient Rights & Responsibilities. I have received a copy of True Precision Medical's Patient Rights & Responsibilities, effective September 30, 2026, which sets out what I can expect from this facility, what is asked of me, whether its physicians hold a financial interest in it, and how to raise a concern. trueprecisionmedical.com/patient-rights	Initial: _____
Financial Policy. I have received and read True Precision Medical's Financial Policy, effective September 30, 2026. I understand that I am responsible for payment for the services I receive, that I assign my insurance benefits to the practice and authorize it to bill my carrier directly, and that charges my carrier does not pay are mine. trueprecisionmedical.com/financial-policy	Initial: _____
Advance directives. I have received True Precision Medical's advance directive policy. If I have a directive that limits resuscitation, I understand my physician will discuss with me before my procedure whether it stays in force, is modified for that period, or is suspended, and that what we decide will be documented. If that conversation has not taken place, this facility will begin life-sustaining measures and activate emergency medical services for transport to a hospital. Nothing agreed here revokes my directive anywhere else.	Initial: _____
Contacting me. I authorize True Precision Medical to contact me about my appointments, my care and my account at the telephone numbers and email address I have given, including a mobile number, by call, voicemail, text message or email. Message and data rates may apply. I may withdraw this consent, or ask for a different method, at any time.	Initial: _____

By signing at the end of this form, I confirm that I have read and agree to each of the items above.

By signing below, I voluntarily consent to all medical and surgical treatment performed by True Precision Medical. I also consent to routine services, diagnostic procedures, medical treatment, or other healthcare services deemed necessary by the health care providers treating me. I understand that I have a right to consent to or refuse to consent any proposed surgery, procedure, or treatment, and to discuss it with my healthcare provider. I understand that if an employee or any individual associated with True Precision Medical is exposed to my blood or bodily fluids, I will be tested for hepatitis viruses and the Human Immunodeficiency Virus (HIV)

The information on this form is accurate to the best of my knowledge:

Signature of Patient/ Legally Authorized Representative _____

Date: _____ Name of Patient/ Legally Authorized Representative _____

Relationship to Patient _____