Throneberry Family Clinic

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2869 College Avenue
Conway, AR 72034
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Re: **Annual Wellness Exam**

Dear Patient:

You recently scheduled an appointment for your Annual Physical. Dr. Throneberry and Dr. Thurow strongly recommend a yearly wellness exam as a part of your overall medical care. Unfortunately, some insurance companies may now only cover what is recommended by the U.S. Preventative Services Task Force. As it has always been our goal to provide you with the best individual medical care, Dr Throneberry and Dr. Thurow recommend the following exams, tests and lab based on your age and gender.

1. Preventative Exam
2. Chest X-ray
3. EKG
4. Pap – Female
5. PSA/Prostate – Male
6. General Health Panel (Lab)
7. Lipid Panel (Lab)
8. Stool Occult & Rectal Exam

We strongly recommend you speak to your insurance company regarding your specific coverage for a routine wellness exam, as some of the above test may not be covered under your plan. After speaking with your insurance company, then you can decide if you do or do not want a test that is not covered by your policy. If you have any questions, feel free to contact our office 501-327-2611.

Thank You,

Throneberry Family Clinic

THRONEBERRY FAMILY CLINIC
PATIENT INFORMATION

PATIENT INFORMATION

Date:_____ Social Security #:_____ - ____-_____ Birthdate:_____

Name:_____
(First) (Middle) (Last)

Address:_____ City:_____ ST:_____ Zip_____

Home phone #:_____ Cell #:_____

Sex: M or F Marital Status : M S D W Email Address:_____

Employer:_____ Work phone #:_____

Employer Address:_____ City:_____ ST:_____ Zip:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Ph. #: _____ Pharmacy:_____

SPOUSE'S INFORMATION

Name:_____ Cell #:_____

Birthdate:_____ SSN# _____-___-_____ Email Address:_____

Employer:_____ Employer Ph#:_____

Employer Address:_____ City:_____ ST:_____ Zip:_____

GUARANTOR INFORMATION (Person responsible for the bill)

If self and contact information is same as above, check here [ ]

Relationship of Guarantor to Patient: Parent _____ Guardian _____ Other_____

Name:_____
(First) (Middle) (Last)

Address:_____ City:_____ ST:_____ Zip:_____

Birthdate:_____ Sex: M or F Home Ph #:_____ Cell Ph #:_____

Employer Name:_____ Work Ph #:_____ Ext:_____

Employer Address:_____ City:_____ ST:_____ Zip:_____

INSURANCE INFORMATION

Primary Insurance:_____ Effective Date:_____

Policy Holder's Name: _____ D.O.B.:_____ SSN#: ____-___-____
(Policy holder's) (Policy holder's)

Policy/ID #:_____ Group #:_____

Claims Address:_____ Ph #:_____

Secondary Insurance:_____ Effective Date:_____

Policy Holder's Name:_____ D.O.B.:_____ SSN#: ____-___-___
(Policy holder's) (Policy holder's)

Policy/ID#:_____ Group #:_____

Claims Address:_____ Ph # :_____

Please list any family members name below that are current patients here:

_____ _____ _____

_____ _____

Signature (if under 18, a parent must sign)

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Comprehensive Patient History Form **Date**_____

Patient Name:_____ DOB:_____
Are you allergic to any Medications? _____ If so, please list:_____

List previous hospitalizations/surgeries/serious injuries When:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Have you ever had the following?

Diabetes……yes no
Hypertension……yes no
Cancer……yes no
Stroke……yes no
Heart trouble……yes no
Arthritis/gout……yes no
Convulsions……yes no
Bleeding tendency……yes no
Acute infections……yes no
Venereal disease……yes no
Hereditary defects…yes no
Other medical not listed..yes no
If Yes, _____

Patient Social History

Marital Status : Single__ Married__ Separated__ Divorced__ Widowed_____
Use of alcohol: Never__ Rarely__ Moderate__ Daily__ , amount_____
Use of tobacco: Never__ Previously but quit__ Current__ , packs per day_____
Use of drugs: Never__ Type/Frequency_____
Excessive exposure at home or work to: Fumes___Dust___Solvents___ Noise___
Employment History (What type of work?)_____

List Medications you are currently taking & dosage:

1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Patient Signature _____ **Physician Signature**_____