Physicians Care Center, Inc.
10034 Brewster Lane
Powell, Ohio 43065
Phone: (614) 761-0555 Fax: (614) 761-8937

PATIENT INFORMATION (Please provide a valid Photo ID at the front desk upon arrival*)

____/____/____ Today's Date
_____ Social Security Number
____/____/____ Date of Birth
_____ Sex

_____ First Name
_____ M.I.
_____ Last Name

_____ Street Address
_____ City
_____ State
_____ Zip

_____ Home Phone (With Area Code)
_____ Work Phone (With Area Code)
_____ Cell Phone (With Area Code)

_____ Email Address
_____ Employer's Name

INSURANCE INFORMATION (Please provide all insurance cards at the front desk upon arrival)

_____ Primary Insurance Name
_____ Secondary Insurance Name

PRIMARY INSURANCE POLICY HOLDER INFORMATION (If different from patient)

_____ Social Security Number
____/____/____ Date of Birth
_____ Sex

_____ First Name
_____ M.I.
_____ Last Name

_____ Street Address
_____ City
_____ State
_____ Zip

_____ Home Phone (With Area Code)
_____ Employer's Name

May we leave a message at your home with other residents? _____Yes _____No
May we leave a message on your answering machine/voice mail? _____Yes _____No
If you are unavailable, to whom may we talk to about your medical concerns?
_____ Relationship? _____
Phone #:_____
Is this contact only for emergency purposes? _____Yes _____No
If no, can we communicate in your behalf? _____Yes _____No
Other Physician to contact? _____
May we provide him/her with updated information? _____Yes _____No

PLEASE TURN PAGE OVER **PLEASE TURN PAGE OVER** **PLEASE TURN PAGE OVER**

Please read the following paragraph and sign below.

I authorize the holder of medical or other information about me to release to the Health Care Financing Administration, Medicare, or its administrators, or to my private insurance carrier(s), any information needed for any claim arising from any services now and hereafter rendered to me by Physicians Care Center Inc. I permit a copy of this authorization to be used in place of the original. I request payment of medical insurance either to myself or to the named insured. I understand that all services not covered by Medicare or other federal programs are the joint and several responsibility of the patient and the responsible party. I consent to any care or treatment my physician associated with Physicians Care Center, Inc. may consider necessary or desirable, consistent with my diagnosis. I fully understand that, except as may otherwise be prohibited by Federal Law, I am responsible for payment at the time of service for all procedures and laboratory tests, and that Physicians Care Center, Inc. will provide all reasonable assistance in assisting me to obtain reimbursement from my insurer(s).

Signature of Patient	Signature of Responsible Party (If different from patient)
Date	Date

*A valid Photo ID is defined as a document that shows the individual's name and current address, includes a photograph, includes an expiration date that has not passed, and was issued by the U.S. Government or a state government.

PHYSICIANS CARE CENTER, INC.

Dr. Richard R. Mason, D.O.
10034 Brewster Lane
Powell, Ohio 43065

Name: _____ Date: _____

Please list the problems you would like the doctor to address:

Physicians Care Center, Inc.
10034 Brewster Lane
Powell OH 43065

Phone: (614) 761-0555 Fax: (614) 761-8937

Patient History

Acctno:_____(Office use only)

Date of Birth:_____/_____/_____

Today's Date:_____/_____/_____

Name:_____
(First Name) (Middle) (Last Name) (Sr., Jr., etc.)

Street:_____

City:_____ State:_____ Zip:_____

Home Phone:(_____) _____-_____ Work Phone:(_____) _____-_____

SSN:_____-____-_____

Occupation(s)?_____

For how long?_____

How did you hear about us?_____

Chief Complaint

Your chief problem(s)?_____

_____

_____

_____

_____

What is the history of the problem(s)?_____

_____

_____

_____

_____

_____

(Please turn to the next page)

Past Medical History

Have you ever had any of the following?
(Please answer Y or N)

Asthma?____	Chronic Lung Disease?__	Ulcer?____
Bladder Disease?____	Diabetes?___	Thyroid Disease?_
Bleeding Disorder?___	High Blood Pressure?___	Tuberculosis?____
Blood Transfusion?___	Kidney Disease?___	
Cancer?___	Heart Attack?____	

Have you had any other significant diagnoses?_____

_____

_____

_____

Please list childhood diseases:_____

_____

_____

Past Surgical History

List your past surgeries (give approximate dates)_____

_____

_____

_____

Current Symptoms

(Answer Y or N. If yes, please give the duration of each)

Cardiovascular/Pulmonary

Headaches?_____
Dizziness?_____
Loss of balance?_____
Nose bleeds?_____
Cough?_____
Cough up blood?_____
Cough up mucus?_____
Leg cramps?_____
Pain, tightness, or pressure in the chest?_____
Shortness of breath upon exertion?_____
Shortness of breath at rest?_____
Shortness of breath lying down?_____
Pain in the legs while walking?_____
Swelling of the ankles?_____
How many pillows do you sleep on at night?_____

Gastrointestinal

Appetite loss?_____
Appetite gain?_____
Difficulty swallowing?_____
Heartburn?_____
Indigestion?_____
Blood in stool?_____
Black stool?_____
Mucus in stool?_____

Nausea?_____
Vomiting?_____
Vomit blood?_____
Abdominal pain?_____
Constipation?_____
Diarrhea?_____
Rectal bleeding?_____

Genitourinary

Pain urinating?_____
Blood in urine?_____
Urine leakage?_____
How often do you urinate at night?_____
How often do you urinate during the day?_____

Neurological

Memory difficulties?_____
Sleep disorder?_____
Fainting spells?_____
Seizures?_____ If yes, please give dates:_____
_____
_____

General

Weight loss?_____
Weight gain?_____
Fatigue?_____
Fever?_____
Chills?_____
Sores in mouth?_____
Joint pain or swelling?_____

Night sweats?_____
Skin itching?_____
Skin rash?_____
Dry skin?_____
Easy bruising?_____

Ear, Nose and Throat

Eye problems?_____
Double vision?_____
Blurring?_____
Nasal obstruction?_____
Sinus congestion?_____
Sore throat?_____
Hoarseness?_____

Ear pain?_____
Hearing loss?_____
Ringing in ears?_____
Discharge from ears?_____

Do you wear glasses, hearing aid(s) or dentures?_____

Female Patients Only

What age did your menstrual periods start?_____

Date of last menstrual period:_____

Are your menstrual periods regular?_____

What is your regular cycle (# of days)?_____

Are your menstrual periods irregular?_____

If yes, list the shortest and longest cycle (# of days)_____

_____

Do you experience severe pain or cramps with periods?_____

Do you currently use birth control pills?_____

Have you at any time in the past?_____ Dates:_____

Number of times pregnant:_____

Number of children:_____

Age menopause began:_____

Age menopause ended:_____

Date of last pelvic examination:_____

Date of last Pap smear:_____

Date of last mammogram:_____

Do you practice breast self examination?_____

Family History

Mother:

Living?_____ Age?_____ Any medical problems? _____

_____

Deceased?_____ Age?_____ Cause of death?_____

_____

Father:

Living?_____ Age?_____ Any medical problems?_____

_____

Deceased?_____ Age?_____ Cause of death?_____

_____

Sisters:

How many living?_____ Age(s)?_____

State medical problems of sisters living_____

_____

How many deceased?_____ Age(s)?_____

State causes of death_____

_____

Brothers:

How many living?_____ Age(s)?_____

State medical problems of brothers living_____

_____

How many deceased?_____ Age(s)?_____

State cause(s) of death_____

_____

Personal Habits

Do you drink coffee, tea, or alcohol?_____

If yes, how much?_____

If yes, how long?_____

Do you use tobacco?_____

If yes, how much?_____

If yes, how long?_____

Any other symptoms not listed? _____

_____

_____

_____

List medications to which you are allergic, if any:_____

_____

_____

_____

List your present medications:_____

_____

_____

_____

List your current supplements, if any:_____

_____

_____

_____

What blood tests, X-rays, CAT scans, MRI, or other tests have you had?_____

_____

_____

_____

_____

_____

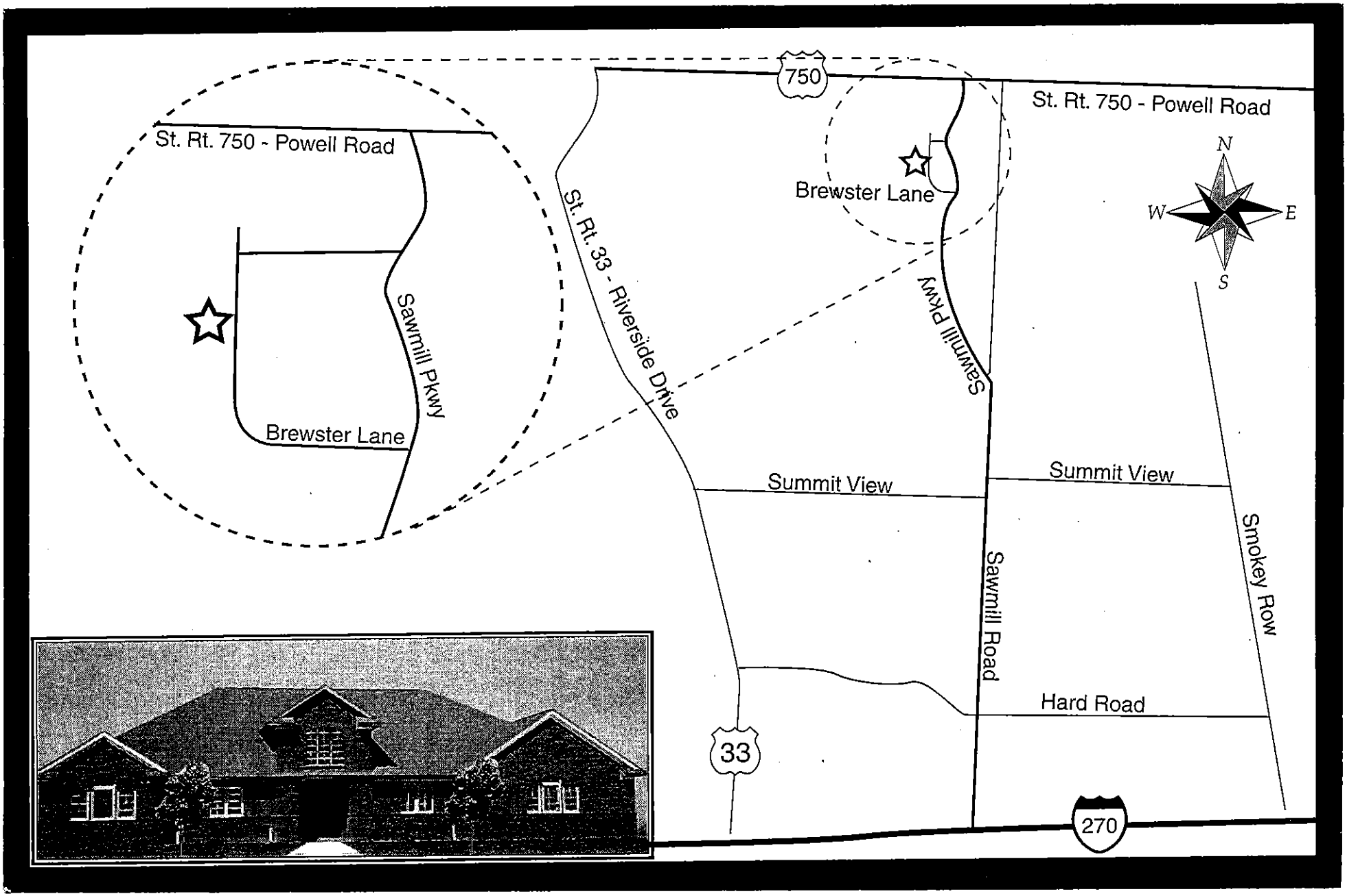
ALL PATIENTS PLEASE READ THE FOLLOWING:

PLEASE USE THE SPACE BELOW TO COMMENT ON ANY ADDITIONAL MEDICAL INFORMATION WHICH YOU BELIEVE WOULD BE HELPFUL IN UNDERSTANDING YOUR MEDICAL PROBLEMS. THANK YOU.

Date:_____/_____/_____

On the date above, the patient and physician have reviewed and discussed this personal medical history, and its relationship to the condition of the patient, and to the prescribed course of treatment.

Patient Signature


St. Rt. 750 - Powell Road
Sawmill Pkwy
Brewster Lane
750
St. Rt. 750 - Powell Road
Brewster Lane
N
W
E
S
St. Rt. 33 - Riverside Drive
Sawmill Pkwy
Summit View
Summit View
Smokey Row
Sawmill Road
Hard Road
33
270

Request for Release of Medical Records

To: _____
(Print physician, clinic, hospital, etc name)

_____
(Street address)

_____
(Additional street address)

_____ , _____ _____
(City) (State) (Zip Code)

_____ _____
Office Phone # Office FAX #

I am requesting that my medical records be promptly sent to:

Richard R. Mason MS, DO, NMD

Physicians Care Center, Inc
10034 Brewster Lane
Powell, OH 43065
FAX # (614) 761-8937
Office # (614) 761-0555

Patient Identification:

Full Name: _____

Address: _____
(Street Address)

_____ , _____ _____
(City) (State) (Zip Code)

____/____/____ ____/____/____
(Date of Birth) (Social Securily Number)

Records requested:

- ☐ All records
- ☐ All records from _____(Date or Specific Treatment)
- ☐ Laboratory, Imaging studies, Operative reports, Consultation reports, History & Physical Exams, & Discharge Summaries.
- ☐ Specific information: _____
  _____

_____ _____
(Patient Signature) (Date)