

## **Provider History Form**

Patient Name:	Date Of Birth:		
In order for us to best assist you with transitioning your medical care, please complete the information below. List the names of any specialty providers or the names of any specialist's clinics you have visited within the last two years. This information may be used to obtain medical records for your provider for treatment, payment, and health care operations as described in the Notice of Privacy Practices.			
Provider Name/Practice Name	Address/Phone Number	Office Use Requested?	
Previous Primary Care Physician:		☐ Yes ☐ No	
Allergist:		☐ Yes ☐ No	
Cardiology/Pulmonology:		☐ Yes ☐ No	
Dermatology:		☐ Yes ☐ No	
Ear, Nose & Throat (ENT):		☐ Yes ☐ No	
Endocrinology:		☐ Yes ☐ No	
Gastroenterology:		☐ Yes ☐ No	
Nephrology:		☐ Yes ☐ No	
Neurology:		☐ Yes ☐ No	
Oncology/Hematology:		☐ Yes ☐ No	
Ophthalmology:		☐ Yes ☐ No	
Pain Management:		☐ Yes ☐ No	
Podiatry/Orthopedic:		☐ Yes ☐ No	
Rheumatology:		☐ Yes ☐ No	
Urology:		☐ Yes ☐ No	
Vascular:		☐ Yes ☐ No	

Other:		□ Yes
ave you had a recent Er visits or hospitalizations?		☐ No  Office Use
lease provide the reason, hospital and dates of admission:		Requested? □ Yes □ No
☐ I do not currently see any specialists.		l No
Signature of Patient	Date	
Signature of Parent/Guardian/Personal Representative*	Date	
Printed Name of Parent/Guardian/Personal Representative*	Date	
*If you are signing as a personal representative of an individuand provide any corresponding documentation (healthcare po		
For Office Use Only:		
Sign and date this form after checking "Yes" or "No" to whether the reco	ords were requested.	
Signature of Office Personnel	Date	
Printed Name of Office Personnel	Date	