

WELCOME TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Home Phone _____
Last Name First Name Initial
Address _____ Cell Phone _____
City _____ State _____ Zip _____ E-mail _____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

PLEASE COMPLETE REVERSE SIDE



REASON FOR VISIT

Please list your present health concerns, problems or symptoms: _____

MEDICAL HISTORY

When was your last physical exam? _____

Physician's Name _____ Phone _____

1. Are you currently under medical treatment?..... Yes No

Please describe: _____

2. Have you ever had any serious illnesses or operations?..... Yes No

Please describe: _____

3. Are you currently taking any medication? Yes No

Please describe: _____

4. Do you smoke? Yes No

5. Do you use alcohol?..... Yes No

6. Do you use cocaine or other drugs? Yes No

7. Have you had any allergic reactions to the following: Yes No

Local Anesthetics (eg. novocaine)

Penicillin or other Antibiotics

Sulfa Drugs

Barbiturates (sleeping pills)

Sedatives

Iodine

Aspirin

Other

Please describe: _____

8. Women Only: Yes No

Do you have regular periods?

Are you taking birth control pills?

Have you ever been pregnant?.....

Number of Pregnancies: _____

Have you ever had the following: Yes No

Anemia (low blood count)

Anorexia (no appetite)

Arthritis

Asthma

Back Problems

Bleeding Tendency

Blood Disease

Cancer

Chemical Dependency (addiction to drugs)

Chemotherapy

Chicken Pox

Chronic Fatigue Syndrome

Circulatory Problems

Congenital Heart Lesions

Cough - persistent or bloody

Diabetes

Emphysema

Epilepsy

Glaucoma

Heart Murmur

Heart Disease

Hepatitis-Type _____

Hernia

Herpes

High Blood Pressure

HIV/AIDS

Jaundice

Kidney Disease

Latex Sensitivity

Liver Disease

Low Blood Pressure

Measles

Migraine Headaches

Mitral Valve Prolapse

Mumps

Multiple Sclerosis

Pacemaker

Pneumonia

Polio

Prostate Problem

Psychiatric Care

Respiratory Disease

Rheumatic Fever

Scarlet Fever

Shortness of Breath

Sinus Trouble

Skin Rash

Stroke

Thyroid Problems

Tonsillitis

Tuberculosis

Ulcer

Venereal Disease

Any Other Condition

Please describe: _____

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____