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 _____