

PATIENT INFORMATION

(Please Print)

Today's Date ___/___/___

Name _____
Last First M.I.

Address _____
Street Name or P.O. Box City State Zip

Home Phone _____ Work Phone _____ SS# _____
Area Code Area Code Patient's Social Security Number

Date of Birth ___/___/___ Sex: Male Female

RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.

Address _____
Street Name or P.O. Box City State Zip

Home Phone _____ Work Phone _____ SS# _____
Area Code Area Code

Date of Birth ___/___/___ Sex: Male Female

WE DO NOT BILL SECONDARY INSURANCE

INSURANCE INFORMATION (Please present insurancecard at time of check in.)

Primary Insurance Name _____	Secondary Insurance Name _____
Ins. Address _____	Ins. Address _____
Name of Insured _____	Name of Insured _____
Insured's ID# _____	Insured's ID# _____
Group # _____	Group # _____
Relationship of patient to the Insured _____	Relationship of patient to the Insured _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
Employer Phone _____ <small>Area Code</small>	Employer Phone _____ <small>Area Code</small>

Other family members that are patients _____

Pharmacy of choice _____ Phone _____

In case of Emergency, who should be notified? _____ Phone _____

Referred by: _____

Primary Care Physician: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature _____ Date ___/___/___

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature _____ Date ___/___/___

Patient Medical History

Patient: _____

Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list:

1. _____ 2. _____

List all Medications you are currently taking:

1. _____ 3. _____
2. _____ 4. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>
			Bowel	<input type="checkbox"/>	<input type="checkbox"/>
			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy		
			or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Vascular:					
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>			
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>			
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>			
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>			

Do you drink alcohol? YES NO If YES _____ drinks per day

Do you use IV drugs? YES NO If YES, what? _____ How much? _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO

Skin:

When you are exposed to sun do you: Tan only Tan and burn Burn

Have you ever had skin cancer? YES NO

Has anyone in your family had skin cancer? YES NO If YES, Who? _____

Do you have a history of any specific skin diseases? YES NO

If yes, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you smoke? YES NO If yes, how much: _____

B. Do you bleed easily? YES NO

C. (Women) Are you pregnant? YES NO Due Date: _____

D. Do you have artificial joint(s)? YES NO

E. What is your occupation? _____

F. What are your hobbies? _____