

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION

Name _____ SS# _____
Last First MI
Address _____ City _____ State _____
Zip _____ Home Ph _____ Cell Ph _____ Email _____
Age _____ Birth Date _____ Single Married Widowed Divorced
Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____
Notify in case of emergency _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last First MI
Relation to Patient _____ Birth Date _____ SS# _____
Address (if different from patient) _____ Ph _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Ph _____
Insurance Company _____ Ph _____
Contract# _____ Group# _____ Subscriber# _____
Name of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Relation to Patient _____ Birth Date _____
Address (if different from patient) _____ SS# _____
City _____ State _____ Zip _____ Ph _____
Subscriber Employed by _____ Business Ph _____
Insurance Company _____ Ph _____
Contract# _____ Group# _____ Subscriber# _____
Name of other dependents under this plan _____

FAMILY MEDICAL HISTORY

	Age	Good Health	Poor Health	Deceased
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Grandparents(s)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MEDICAL HISTORY

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give dates _____

Are you pregnant? Y N Nursing? Y N Taking birth control? Y N

Check (✓) if you have had any of the following:

- | | | | | |
|--------------------------------------------------|----------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> AIDS/HIV + | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach/Intestinal problems |
| <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart problems Describe _____ | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cholesterol problem | <input type="checkbox"/> Hemophilia/ Abnormal bleeding | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker/Heart surgery | <input type="checkbox"/> STDs |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Cortisone treatment | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hereditary Problems | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Food allergies | | <input type="checkbox"/> Seizures | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Headaches | | <input type="checkbox"/> Skin rash | |

List medications you are currently taking, if any:

List drug allergies, if any:

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor.

I authorize my insurance company to pay to the doctor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment due in full at time of service unless prior arrangements have been approved.