Patient Legal Name **Last** **First** **Middle Initial** **Today's Date**

→

Mailing Address **Street** **City and State** **Zip** **Home Telephone**

→

Age Birth Date Gender Marital Status **Cell Phone**

M O F O S O M O W O D O

Race Social Security No Email Address

Employer's Name and Address Street City and State Zip Business Telephone

Patient's Occupation Emergency Contact other than Spouse Emergency Telephone

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Responsible Party/Spouse Name Birth Date Social Security No Relationship to Patient

Street Address City and State Zip Code Home Telephone

Responsible Party/Spouse Occupation Responsible Party/Spouse Employer

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

Ins Co Name_____

Policy Holder Name_____

D.O.B._____Employer_____

SECONDARY INSURANCE COMPANY

Ins Co Name_____

Policy Holder Name_____

D.O.B._____Employer_____

REFERRAL INFORMATION

REFERRAL BY A DOCTOR **Please fill in:** **REFERRAL BY A FRIEND OR FAMILY MEMBER**

Physician Name **Physician Phone** **Name** **Relationship to Patient**

MEDICAL QUESTIONS

Are you ALLERGIC to any MEDICATION?

If YES, please list them: NO O YES O

_____

_____

_____

_____

ALLERGY TO LATEX? NO O YES O

List All Medications currently taking:

_____

_____

_____

_____

_____

_____

Pharmacy Name and Address:

_____

_____

List Previous Hospitalizations:

_____

_____

List Previous Surgeries:

_____

_____

List Medical Problems that run in your family:

_____

_____

Please List your Personal PHYSICIAN/Address:

_____

_____

Do you have now, or have you ever had diseases or conditions listed below:

Lungs	YES	NO
Bronchitis	O	O
Asthma	O	O
Emphysema	O	O

Vascular	YES	NO
High Blood Pressure	O	O
Chest Pain	O	O
Heart Attack	O	O
Irregular Heart Beat	O	O
Phlebitis	O	O
Defibrillator	O	O
Pacemaker	O	O
Bleeding Problems	O	O
Do You Smoke?	O	O

Other Systemic:	YES	NO
Glaucoma	O	O
Diabetes	O	O
Thyroid	O	O
Kidney	O	O
Bladder	O	O
Stomach	O	O
Bowel	O	O
Genital Problems	O	O
Arthritis, Joint deformity	O	O
Artificial Joints	O	O
Convulsions, Epilepsy, or seizures	O	O
Fainting	O	O
Neurological/Psychiatric	O	O
SKIN CANCER	O	O

Other Skin Diseases_____

_____

_____

If Female, are you Pregnant? YES NO

Due Date?_____ O O

If Female: Last Menses _____

Other Medical Problems not listed:_____

_____

HAVE YOU HAD ANY OF THE FOLLOWING SERIOUS CONDITIONS?

Hepatitis A ☐ B ☐ C ☐ YES O NO O HIV YES O NO O

Tuberculosis YES O NO O MRSA YES O NO O

AUTHORIZATION TO TREAT

I (or the undersigned on behalf of the patient) authorize the attending physician(s) or his/her designee under supervision, to provide medical treatment. I understand I am financially responsible for and agree to pay charges not paid by my insurance company. Date:_____

Patient/Legal Guardian Signature:_____**Print Name:**_____