Name: ____ **DOB:** _________________ **Sex:** _________

Soc. Sec.: ______-_____-______ **Marital Status: M/Married S/Single D/Divorced W/Widowed**

Address: _______________________________________**City:** ____________________ **Zip Code:** __________

Home Ph: (_______) _________-___________ **Cell Ph:** (______) __________-__________

Emergency Contact Person: ____

Relationship ________________________________ **Phone:** (________) __________-_____________

PCP: __________________________**Office Address/Ph:**____

Doctor Req. Consult (if different from PCP): ____

Pharmacy: ____________________________________ **Ph:** ____

Primary Insurance

Name: _____________________________________

Employer: __________________________________

Work Ph: ________________________________

SSN: _________________________________

DOB: ________________________________

Primary Ins: ____________________

Policy # ______________________________________

Secondary Insurance

Name: ____________________________________

Employer: _________________________________

Work Ph: ______________________________

SSN: ________________________________

DOB: ______________________________

Secondary Ins: ____________________

Policy # ____________________________________

Authorization to release Information: I authorize the Doctor to release any medical information necessary to process my claim form.

Authorization to pay benefits to Physician: I authorize payments for surgical and/or medical treatments to the doctor directly. I understand that I am responsible for paying for services that are not covered.

Signed: ____ **Date:** _______________________________

I understand that the parent or caregiver of a minor patient is responsible for all services to be received.

____ ____

Signature **Print name**

I, as a member of _____________________**health plan, am responsible for obtaining a referral for each visit to a specialist. If I do not have a valid referral for a visit, I withdraw the right to use this insurance, and will be responsible for payment for the visit.**

Signed: ____________________________________ **Relationship (if not filled out by patient):** ______________________

Acct # __________________________

Medical History

Name ____ Age _________ Gender F M Height________ Weight________

REASON FOR VISIT TODAY: ____

PRIMARY DOCTOR: ___________________________________OTHER DOCTORS TREATING YOU: _______________________________

____

Past Medical History Please circle your current and previous medical problems. NONE

High Blood Pressure	Congestive Heart Failure	Heart Attack	Angina	Heart Murmur
Mitral Valve Prolapse	Diabetes	Asthma	Environmental Allergies	Heartburn/Acid Reflux
Pneumonia	Emphysema/COPD	Prostate Problems	Bladder Trouble	Thyroid Disease
Back/Joint Problems	Epilepsy	Hepatitis	Jaundice	Glaucoma

Other: ____

Review of Systems **Please circle any of the symptoms you are experiencing.** NONE

Fever	Vision Changes	Difficulty Swallowing	Hoarseness	Wheezing
Shortness of Breath	Chest Pain	Nausea/Vomiting	Painful Urination	Joint Pain
Rashes	Facial Numbness	Depression	Frequent Thirst	Prolonged Bleeding

Female patients: Could you possibly be pregnant? Yes No Date of last menstrual period: _________________

Past Surgical History

Please list all prior surgeries (even from childhood) with dates

1. ____

2. ____

3. ____

Allergies List all drug allergies and indicate type of reaction **1.** ____

Latex Allergy? Yes No **2.** ____

Medications List all prescription and non-prescription medications with dosages.

Prescription: **1.** _____________________________________ **6.** _____________________________________

2. _____________________________________ **7.** _____________________________________

3. _____________________________________ **8.** _____________________________________

4. _____________________________________ **9.** _____________________________________

5. _____________________________________ **10.** _____________________________________

Non-Prescription: **1.** _____________________________________ **2.** _____________________________________

Do you take Aspirin, Ibuprofen, Advil, Motrin or any medication containing Aspirin? Yes No Name _____________________

Social History Occupation: __________________________________

Do you smoke?: Yes No If yes, ____________ packs per day If you quit, what year? __________

Alcohol ___________ drinks per day Caffeine ___________ cups per day Chewing Tobacco: Yes No

Family History Have you or any blood relative had any problems with anesthesia or bleeding? If yes, please explain.

____

I have answered the above completely, and to the best of my abilities.

_______________________________________ _______________________________________

Patient Signature Date Reviewed with patient/Doctor Signature Date