

NEW PATIENT INFORMATION

Name _____
Street Address _____
City _____ State _____ Zip _____
Date of Birth _____ Marital Status _____ Sex _____ SS# _____
Home Phone () _____ Work Phone () _____
Employer _____
E-mail Address _____
(May we please have your e-mail address so we can send you information about our services)

Who Is Your Medical Doctor Internist/General Practitioner

Name _____ M.D. _____
Address _____ Phone () _____
City _____ State _____ Zip _____
Did he refer you for consultation? Yes No Letter to referring Doctor? Yes No

Referred By: Physician Family/Friend Internet Advertisement Yellow Pages Insurance Plan

Policy Holder / Primary Insurance Information

Name _____ SS# _____ DOB _____
Name of Insurance Company _____ ID/Policy # _____ Group # _____
Insurance Company Address _____
Relationship to Patient _____

Secondary Insurance To File

Name of Insurance Company _____ Policy # _____ Group # _____
Policy Holder Name _____ Relationship to Patient _____
Social Security # or ID # _____
Insurance Company Address _____ D.O.B.: ____/____/____ SS# _____

Do we have your permission to:

- Leave a message on your answering machine at home? YES NO
Leave a message at your place of employment? YES NO
Discuss your medical condition with any member of your household? YES NO

If yes, whom: _____ Relationship _____

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office, i.e., insurance cards and referrals, and if I do not, I will be responsible for payment that day and will be reimbursed if I present such within 24 hours. If I do not pay your copay at time of visit, an additional administration fee of \$10.00 will be charged. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature _____ Date _____

MEDICAL HISTORY

Patient: _____

Date taken: _____

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. _____ 5. _____
2. _____ 4. _____ 6. _____

History of Diseases

Do you have now, or have you ever had diseases or conditions of:

	Yes	No		Yes	No
Lungs:			Other Systemic:		
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"/>
Vascular:			Hepatitis or Yellow Skin	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions, Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mitral Valve Prolapse	<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 been or have you ever been exposed to any infections disease(s)? Yes No

Have you ever had dental anesthesia (Novacaine)? Yes No Any bad reaction? Yes No

Do you prophalax before dental procedures? Yes No

Do you have a latex allergy? 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 / melanoma? Yes No If yes, who? _____ Type? _____

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: _____

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. What is your occupation? _____

E. What are your hobbies? _____

Completed by: Patient
 L.P.N. - R.N. _____

Initials

Reviewed by: _____

Signed by Physician

Date