PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____ _____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____
_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring You? _____

PHONE NUMBERS

Home (_____)_____ Cell (____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone (____)_____

Work Phone (____)_____

INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance Co. _____

Group # _____

Is patient cover by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birth date _____ SS# _____

Relationship to patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company (ies)

and assign directly to Dr._____
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

FAMILY HISTORY

Date of last physical examination _____

What is the reason for your visit? _____

ALIVE DECEASED	Father ☐ ☐	Present health or cause of death	Mother ☐ ☐	Present health or cause of death	Spouse ☐ ☐	Present health or cause of death
BROTHERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		NO. DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		NO. DECEASED	AGES & CAUSE OF DEATH	

Check illnesses which have occurred in any of your blood relatives

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart Disease ☐ Stroke ☐ High Blood Pressure ☐ Nervous Illness ☐ Allergy ☐ Other

HEALTH HISTORY

Check symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, Weakness, Numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nose bleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-Flashes/Halo

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY

- ☐ Erection Difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last period _____

Date of last pap smear _____

Have you had a mammogram? ___

Are you pregnant? _____

Number of children _____

Check conditions you have or have had in the past

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

MEDICATION/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (_____) _____

List allergies to medications or substances _____

_____

HEALTH HABITS

Check which you use and how much:

- ☐ Caffeine
- ☐ Street Drugs
- ☐ Tobacco
- ☐ Other

Check if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other

Alcohol: _____

SIGNATURES

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Reviewed by: _____ Date: _____