PATIENT INFORMATION

Date

Name _____ Birthdate _____ Home Phone (_____)_____

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐ F ☐Married ☐ Widowed ☐Single ☐Minor

☐Separated ☐ Divorced ☐Partnered for _____years

E-Mail _____ Cell Phone (_____)_____

SS # _____ Whom may we thank for referring you? _ _____

Employer/School _____ Employer/School Phone (_____)_____

Spouse or Parent Name _____ Employer _____

Person to contact in case of emergency _____ Phone (_____)_____

Relationship to Patient _____

RESPONSIBLE PARTY

Name of person Responsible for this account _____

Relation to patient _____ Address _____

Employer_____ Birthdate _____ Phone (_____) _____

Currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION

Name of insured _____ Relation to patient _____

Birthdate _____ SS # _____ Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Insurance Company Phone (_____) _____

ADDITIONAL INSURANCE

Name of insured _____ Relation to patient _____

Birthdate _____ SS # _____ Employer _____

Employer Address _____

Insurance Company _____ Group # _____

Insurance Company Phone (_____) _____

Health History

AIDS/HIV	❑Yes	❑No	Epilepsy	❑Yes	❑No	Respiratory Disease	❑Yes	❑No
Anemia	❑Yes	❑No	Glaucoma	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No
Arthritis	❑Yes	❑No	Headaches	❑Yes	❑No	Scarlet Fever	❑Yes	❑No
Artificial Heart Valve	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Sinus Trouble	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Heart Problems	❑Yes	❑No	Stroke	❑Yes	❑No
Asthma	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Thyroid Problems	❑Yes	❑No
Back Problems	❑Yes	❑No	Herpes	❑Yes	❑No	Tonsillitis	❑Yes	❑No
Bleeding Abnormally	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Tuberculous	❑Yes	❑No
Blood Disease	❑Yes	❑No	HPV	❑Yes	❑No	Tumor or Growth	❑Yes	❑No
Cancer _____	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Ulcers	❑Yes	❑No
Chemical Dependency	❑Yes	❑No	Liver Disease	❑Yes	❑No	Venereal Disease	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Low Blood Pressure	❑Yes	❑No	Osteporosis	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Have you ever taken any of the following?		
Congenital Heart Lession	❑Yes	❑No	Nervous Problems	❑Yes	❑No	Fosamax, Fosamax-D, Boniva, Actonel		
COPD	❑Yes	❑No	Pace Maker/defibrillator	❑Yes	❑No	Aredia, Didronel, Reclast, Skelid, or Zometa		
Diabetes	❑Yes	❑No	Radiation Treatment	❑Yes	❑No			
Emphysema	❑Yes	❑No	Depression	❑Yes	❑No	Women:		
Sleep Apnea	❑Yes	❑No	Anxiety Disorder	❑Yes	❑No	Are you pregnant	❑Yes	❑No

Prescribed Medications

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Why do you take this medication?

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Any Surgical Procedures

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List all allergies

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Pharmacy Name

_____

Phone Number

(_____) _____

Primary Care Physician's Name

_____

Phone Number

(_____) _____

Location _____