Patient Information

Patient Name: ______________________________ Date: ____________
Last, First, MI (Preferred Name)

Social Security #: ______________________________ Birth Date: ____________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Email: ______________________________ Cell: ____________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Who should we notify in case of emergency? ______________________________
Name Phone #

Health Information

Date of last Medical Exam: ____________ Reason for visit: ____________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Arthritis
- ☐ Allergies ____________
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fatigue
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Migraine
- ☐ Nervous Disorders
- ☐ Pace Maker
- ☐ Are you Pregnant? Due Date: ____________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

List of Allergies to Medications:

____

____

____

Are you taking any medication (including non-prescription)? If so, please list:

____

____

____

* Have you been to the ER or under the care of a physician in the last 12 months? ☐ Yes ☐ No

* Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________

* Name of Primary Care Physician: ______________________________ Phone: ____________

* Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.
I acknowledge that insurance benefits are a contract between the patient and the insurance company and that all charges incurred are the responsibility of the patient even if the insurance company declines payment.

Signature of patient or guardian: ______________________________ Date: ____________

OVER

Medical Update (Office Use Only)

Date	Comments	Init

Spouse or responsible party information

The following is for: ☐ The patients spouse ☐ The person responsible for payment

Name:______________________ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #:______________________ Birth Date:______________________

Phone (Home):______________________ (Work)______________ Ext__________ Best time to call______________

Address:____
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ The patients spouse ☐ The person responsible for payment

Employer Name:______________________ Occupation:______________________

Address:____
Street City, State, Zip Code Phone

Insurance Information

PRIMARY

Name of insured:______________________ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date:______________ I.D.#:______________ Group #:______________

Insured's Address:____
Street City State Zip Code

Insured's Employer Name:____

Address:____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address:____

____

____

SECONDARY

Name of insured:______________________ Is insured a patient? ☐ Yes ☐ No

Insured's Birth Date:______________ I.D.#:______________ Group #:______________

Insured's Address:____
Street City State Zip Code

Insured's Employer Name:____

Address:____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other______________

Insurance Plan Name and Address:____

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Referral Information

Whom may we thank for referring you to our office? ____

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