

PATIENT INFORMATION

DATE _____

NAME (as on SS card): _____
(First) (M) (Last)

WHAT DO YOU PREFER TO BE CALLED: _____

PREVIOUS NAME _____ SEX: MALE _____ FEMALE _____

ADDRESS: _____
(Street/PO Box) (City) (State/Zip Code)

PHONE

Home () _____ Work() _____ Cell () _____

BIRTHDATE: ____/____/____ AGE: _____ SOCIAL SECURITY # _____

OCCUPATION: _____ EMPLOYER: _____

SPOUSE NAME: _____ SPOUSE WK OR CELL# () _____

ALTERNATE NOTIFICATION: _____ PHONE:() _____

Relationship: Parent / Grandparent / Son / Daughter / Spouse / Neighbor / Friend / Other

MINOR (18 & under) Lives with (names): _____

Relationship: Both Parents / Mother / Father / Guardian

Mother SS# _____ Father SS# _____

Mother Work # () _____ Father Work # () _____

PRIMARY INSURANCE: _____ Through Work Place: Yes / No

Name of Employer: _____

Address _____ Phone# () _____

Subscriber Name: _____ SS# _____ Birthdate ____/____/____

Relationship to patient: Self / Spouse / Parent / Dependent Child / Other

SECONDARY INSURANCE: _____ Through Work Place: Yes / No

Name of Employer: _____

Address _____ Phone# () _____

Subscriber Name: _____ SS# _____ Birthdate ____/____/____

Relationship to patient: Self / Spouse / Parent / Dependent Child / Other

TERTIARY INSURANCE: _____ Through Work Place: Yes / No

Name of Employer: _____

Address _____ Phone# () _____

Subscriber Name: _____ SS# _____ Birthdate ____/____/____

Relationship to patient: Self / Spouse / Parent / Dependent Child / Other

REFERRING DOCTOR _____ MD/DO/OD/PA/NP _____
(Name) (City/State)

FAMILY DOCTOR _____ MD/DO/PA/NP _____
(Name) (City/State)

OTHER REFERRAL SOURCE _____

MEDICAL HISTORY

PATIENT NAME: _____ **BIRTHDATE** _____ **DATE** _____

LIST PRIMARY SYMPTOMS OR PROBLEMS THAT BRING YOU TO SEE THE DOCTOR:

List **ALL** prescription and non-prescription medications you are currently taking including the reason you are taking them.
(Please take information directly from the medicine bottle, i.e.: name of medication and instruction for it's use)

List any medication you are allergic to:

List **ALL** hospitalizations (surgical or nonsurgical) and dates:

Briefly list any past or present medical problems:

List any pertinent family medical history:

HABITS: Do you currently chew tobacco? Yes / No How much/often? _____
Have you chewed tobacco in the past? Yes / No How much/often? _____
Do you currently smoke? Yes / No How much/often? _____
Have you smoked in the past? Yes / No How much/often? _____
Do you presently use alcohol? Yes / No How much/often? _____

Do you have a religious preference that affects your ability to receive blood or blood products: Yes / No

WHAT PHARMACY DO YOU PREFER TO USE? _____ **PH#** () _____

DO YOU HAVE CALLER ID? Yes / No **DO YOU HAVE AN ANSWERING MACHINE?** Yes / No

May we leave a detailed medical message on the answering machine? Yes / No **With a family member?** Yes / No

If yes, please list specific names: _____