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

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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

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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: _____

_____