Patient Information

Patients Last Name:________________ First Name:____________ Middle Initial:____ Date:__________

Address:____________________ City:________ State:____ Zip:______ Home Phone:__________

Soc. Sec. #:______________ Date of Birth:__________ Age:_____ Sex:_____ Cell Phone:__________

Occupation:______________ Marital Status: **S M D W** Referred By:________________

E-Mail Address:____

Insurance Information

Primary Ins. Co.:________________________ Subscriber's Soci. Sec. #:____________

Subscribers Name:________________________________ Subscribers Birth Date:____________

Relationship to Subscriber:____________ Subscriber ID #:____________________________

Secondary Ins. Co.::______________________ Subscriber's Soci. Sec. #:____________

Subscribers Name:______________________________ Subscribers Birth Date:____________

Relationship to Subscriber:____________ Subscriber ID #:____________________________

Physician and Pharmacy Information

Physician's Name:____________________ Phone Number:__________ Date Last Seen__________

Pharmacy:__________________________ Pharmacy Phone Number:______________

Assignment of Insurance Benefits & Office Policy

I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient t cover the entire medical and surgical expense, I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill. If I am late I understand that there is a finance charge of 1.9% per month, as well as all collection costs, court cost, attorney fees, filling fees, and interest fees accrued with the collection of this account.

Our office accepts cash and or checks or credit cards as payment for services rendered.

Please be advised that Medicare and/or your private health insurance carrier may not cover certain procedures or services that your doctor deems necessary for complete evaluation and management of your care. This may include various ultrasound procedures, injections, diagnostic test, etc. Please note that you may be responsible for any balance not paid by your insurance company.

Also, please be advised that if your insurance company requires a referral or an authorization for any services or procedures performed it is your responsibility to present a valid referral or authorization prior to services being rendered.

Current insurance regulations require us to notify you, the patient, of this information prior to your treatment.

Patient Signature: ______________________________ **Date:** ______________

Medical History

Please check all that apply

- ☐ Yes, I am in good health
- ☐ I am pregnant
- ☐ Diabetes Mellitus
  - ☐ Type I
  - ☐ Type II
  - ☐ Insulin dependent
  - ☐ Non-Insulin dependent
- ☐ Take Blood Thinners
- ☐ Cardiac (Heart) Disease
  - ☐ Cardiac Arrhythmias
  - ☐ Pacemaker
  - ☐ Murmur, Valve Problem
  - ☐ Rheumatic Heart Disease
  - ☐ Rheumatic Fever
- ☐ Arthritis
- ☐ Asthma
- ☐ AIDS/HIV
- ☐ Alcoholism/Drug Addiction
- ☐ Aortic Aneurysm
- ☐ Arteriosclerosis
- ☐ Circulation Problems/PVD
- ☐ Dizziness/Fainting
- ☐ DVT (Blood Clot)
- ☐ Edema (Swelling)
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Gastrointestinal Problems
- ☐ Glaucoma
- ☐ Gout
- ☐ Liver Problems
- ☐ Hepatitis
- ☐ Herpes
- ☐ Hyperlipidemia
- ☐ Kidney Problems
- ☐ Collagen Vascular Disease, i.e Lupus, Scleroderma, Dermatomyositis, RA
- ☐ Keloid Formation
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psychiatric Problems
- ☐ Sleep Disorder
- ☐ STD's
- ☐ Stroke/CVA
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Weight Change
- ☐ Hypertension
- ☐ Hypotension
- ☐ Celiac Disease
- ☐ Chicken Pox/Shingles
- ☐ Cancer

Social History

- ☐ Tobacco: currently
- ☐ Tobacco: previous
- ☐ Alcohol
- ☐ Recreational Drugs

Allergies

- ☐ Penicillin
- ☐ Iodine
- ☐ Codeine
- ☐ Latex

Do you have anything not mentioned here (Medical History, Allergies or Social History)?

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Review of Systems

Please check all that apply

Constitutional Symptoms
- ☐ Normal
- ☐ fever
- ☐ chills
- ☐ headache

Eyes
- ☐ Normal
- ☐ blurred vision,
- ☐ light sensitivity
- ☐ watery eyes

Ears, Nose, & Throat
- ☐ Normal
- ☐ congestion
- ☐ drainage
- ☐ difficulty swallowing
- ☐ ringing in ears
- ☐ pain
- ☐ bleeding

Integumentary
- ☐ Normal
- ☐ rash
- ☐ persistent itch
- ☐ tattoo

Allergic
- ☐ Normal
- ☐ hay fever
- ☐ drug
- ☐ allergies

Musculoskeletal
- ☐ Normal
- ☐ joint pain
- ☐ neck pain
- ☐ back pain

Neurological
- ☐ Normal
- ☐ Seizures
- ☐ Stroke

Genitourinary
- ☐ Normal
- ☐ inability to urinate
- ☐ painful urination

Endocrine
- ☐ Normal
- ☐ excessive thirst
- ☐ too hot/cold
- ☐ tired/sluggish

Respiratory
- ☐ Normal
- ☐ frequent cough
- ☐ wheezing
- ☐ shortness of breath

Gastrointestinal
- ☐ Normal
- ☐ abdominal pain,
- ☐ nausea/vomiting
- ☐ indigestion/heartburn

Cardiovascular
- ☐ Normal
- ☐ chest pain
- ☐ palpitations
- ☐ irregular heartbeat
- ☐ PND
- ☐ orthopnea

Hematologic
- ☐ Normal
- ☐ swollen glands
- ☐ blood clotting problem

Psychiatric
- ☐ Normal
- ☐ not satisfied with life
- ☐ depression
- ☐ considered suicide

Surgical History: ______________________________

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List all of the medications that you are currently taking: ______________________________

____

Shoe Size: ____________ ☐ *men's* ☐ *women's*

Family History

Circle M, F, or both: M=Mother F=Father please chck all that apply

	Condition	M	F
☐	Acne	M	F
☐	Acute rheumatic fever	M	F
☐	Attention Deficit Hyperactivity Disorder	M	F
☐	Age related macular degeneration	M	F
☐	Alzheimers	M	F
☐	Angina	M	F
☐	Ankylosing spondylitis	M	F
☐	Atheroslerosis	M	F
☐	Autism	M	F
☐	Bipolar attack	M	F
☐	Bladder Cancer	M	F
☐	Bleeding disorders	M	F
☐	Breast cancer	M	F
☐	Cancer	M	F
☐	Cardiac Arrythmia	M	F
☐	Cardiovascular disease	M	F
☐	Celiac disease	M	F
☐	Circulatory disorders	M	F
☐	Circulatory problems	M	F
☐	Colorectal cancer	M	F
☐	Colorectal polyps	M	F
☐	Congenital conditions	M	F
☐	Coronary heart disease	M	F
☐	Crohn's disease	M	F
☐	Cyclic vomiting syndrome	M	F
☐	Dementia	M	F
☐	Depression	M	F
☐	Diabetes-type 1	M	F
☐	Diabetes-type2	M	F
☐	Duodenal ulcer	M	F
☐	Eczema	M	F
☐	Emphysema	M	F
☐	End-stage renal disease	M	F
☐	Familial emphysema	M	F
☐	Genetic disease	M	F
☐	Gestational diabetes	M	F
☐	Glaucoma	M	F
☐	Heart attack	M	F
☐	Heart disease	M	F
☐	Heart failure	M	F
☐	Hemochromatosis	M	F
☐	Hepatitis	M	F
☐	Hepatoma	M	F
☐	High cholesterol	M	F
☐	Hirschprung's disease	M	F
☐	Hodgkin's disease	M	F
☐	Hypertension	M	F
☐	Hyperthryoidism	M	F
☐	Hypertrophic cardiomyopathy	M	F
☐	Hypothyroidism	M	F
☐	Kidney problems	M	F
☐	Kidney stones	M	F
☐	Learning disabilities	M	F
☐	Liver Cancer	M	F
☐	Liver problems	M	F
☐	Melanoma	M	F
☐	Migraine headaches	M	F
☐	Multiple Myeloma	M	F
☐	Narcolepsy	M	F
☐	Neurologic disorder	M	F
☐	Obcessive Compulsive Disorder	M	F
☐	Obcessive Compulsive Personality Disorder	M	F
☐	Osteoporosis	M	F
☐	Ovarian cancer	M	F
☐	Pancreatic cancer	M	F
☐	Psychiatric disorder	M	F
☐	Presbycusis (Age-related hearing loss)	M	F
☐	Primary pulmonary hypertension	M	F
☐	Prostate cancer	M	F
☐	Psoriasis	M	F
☐	Psychiatric disorder	M	F
☐	Respiratory Problem	M	F
☐	Rheumatic fever	M	F
☐	Rheumatoid arthritis	M	F
☐	Rosacea	M	F
☐	Schizophrenia	M	F
☐	Scoliosis	M	F
☐	SIDS (Sudden Infant Death Syndrome)	M	F
☐	Stroke (CVA)	M	F
☐	Thyroid cancer	M	F
☐	Uterine cancer	M	F
☐	Vaginal cancer	M	F
☐	Varicose veins	M	F
☐	Vitiligo	M	F

☐ I do not have any history of family diseases or familial tendencies that I am aware of.________________________

Signature Date

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Name: Date:

Marital Status:
Who do you live with:
How many Children:
Employment:
Occupation (current or former):
Do you smoke?
How much do you smoke per day?
Do you drink caffeinated beverages (cola, coffee, or tea)?
Number per day:

Height:
Weight:
Blood Pressure:
Flu Shot?
Nationality:
Email Address: