Timothy A. Nielsen MD

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Patient: _____ Date: _____

Address: _____ City/State: _____

Zip Code: _____ Date of Birth: _____ Gender: __

Phone Number (day): _____ Mobile number: _____

Patient Social Security #: _____Driver License Number: _____

Email Address: _____

Patient's Employer: _____ Occupation: _____

Address of Employment: _____ Phone #: _____

Referred by: _____ Primary Care Physician: _____ Phone #: _

Who to contact in case of emergency: _____

Name of Spouse: _____ (or if minor, responsible parent): _____

Medicare Number: _____

Private or Supplement Insurance: _____

Insured: _____ Patient: _____ Spouse: _____Parent: _____

Insureds Date of Birth: _____

Contract #: _____ Group Number: _____

I am paying today by: Cash: _____ Credit Card: _____

Do we have permission to (circle all that apply)?
Leave a message at your place of employment?
Leave a message on your answering machine at home?
Email you? Text You?
Discuss your medical condition with a member of your household?
If yes whom: _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. All court fees, attorney fees or other fees necessary to collect on this account are payable by me. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature: _____ Date: _____
Parent (if minor): _____ Date: _____

WE WILL ACCEPT ASSIGNMENT WITH MEDICARE ON SERVICES RENDERED TO MEDICARE PATIENTS. ALL MEDICARE PATIENTS WILL BE RESPONSIBLE AT THE TIME OF VISIT FOR THEIR 20% AND ANY PART OF THEIR DEDUCTIBLE THAT HAS NOT BEEN MET.

Updated by: _____
Date & Initial

Past Medical History: (please circle all that apply)
Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss

Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None:

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
None/Other

Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Carcinoma Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

_____
_____

Skin Disease History:(please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or itchy scalp
None/Other: _____
Hay Fever /Allergies
Melanoma
Poison Ivy
Precancerous Mole
Psoriasis
Squamous Cell Skin Cancer

Do you have a family history of Melanoma? Yes, No

If yes, which relatives? _____

Do you wear Sunscreen? Yes, No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes, No

Family History: (please circle all that apply)
Blindness
Cancer
Cataracts
CVA
Diabetes
Glaucoma
Heart disease
Other:
_____
Macular degeneration
Migraine
Retinal detachment
Strabismus
None

Medications: (Please list all current medications)
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
None

Social History: (Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Sexual History: (Please circle all that apply)

- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

Illicit Drug Use:

- Drug Use
- IV Drug Use

Alcohol Use:

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

Other_____

Review of Systems: Are you currently experiencing any of the following?
(please check yes or no for the following)

Symptoms:	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scaring		
Rash		
Itching		
Immunosuppression		

Other Symptoms: _____

Alerts: Are you currently experiencing any of the following?
(please check yes or no for the following)

Alert	Yes	No
Allergy to Adhesive or Band-Aid's		
Allergy to lidocaine		
Allergy to topical antibiotics		
Artificial heart valve		
Artificial joint replacement		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Require Antibiotics prior to a surgical procedure		
Rapid heartbeat with epinephrine		
Are you pregnant or currently trying to get pregnant		

Other Symptoms: _____

Pharmacy:

Preferred Pharmacy Name: _____

Pharmacy Phone #: _____

Phatmacy Address: _____

Pharmacy City or Zip Code: _____

THANK YOU!
Dr. Nielsen
&
Staff