Patient Information Today's Date ____/____/ 2019

Last Name _____ First Name _____ M_____

Social Security # _____ Medical Insurance _____

Address _____ City _____ State _____ Zip_____

Date of Birth _____/_____/_____ Age _____ Sex: Male Female Other _____

Home Phone _____ Cell _____ Email _____

Primary Care Physician: _____ Phone _____
Last Date seen _____

Emergency Contact: _____ Phone Number _____
Relationship to Patient _____

Reason for Visit

_____

Please list all Medications (❑ None)

_____

_____

Allergies (❑ None) _____

Past Medical History (Circle all that apply)

AIDS/HIV	Atrial Fibrillation	Cancer	Hepatitis	Neuropathy
Anemia	Back Pain	Diabetes Insulin	High Blood Pressure	Psychiatric Care
Arthritis	Bleeding Disorder	Diabetes Non-insulin	High Cholesterol	Renal/Kidney Disease
Asthma	Blood Clots	Gout	Liver Disease	Stroke
		Heart Disease	Lung Disease/COPD	Other _____

List Any Prior Surgeries

_____

_____

Family History: Diabetes Heart Disease Cancer Bleeding Disorders Other _____

Smoking? Never Former Every Day Some Days **Alcohol use?** None Rare Social Frequent

Height _____ **Weight** _____ **Occupation** _____

How did you hear about us? ❐ **Dr. Berkowitz** ❐ **Patient Referral** ❐ **Urgent Care** ❐ **Insurance Provider**

❑ **Internet search** **Other** _____

Treatment Consent

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature _____ Date _____