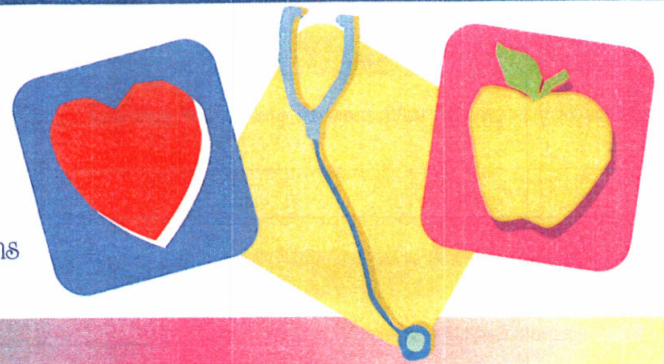


WELCOME TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____
Name _____ Home Phone _____
Last Name First Name Initial
Address _____ Cell Phone _____
City _____ State _____ Zip _____ E-mail _____
Sex: M F Minor Single Married Long Term Partner Divorced Widowed Separated
Employer _____ Business Phone _____
Business Address _____ Occupation _____
Who should we thank for referring you? _____
In case of emergency, who should we contact? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Responsible Party Employed By _____ Business Phone _____
Business Address _____ Occupation _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

ADDITIONAL INSURANCE

Insured Name _____
Last Name First Name Initial
Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____
City _____ State _____ Zip _____
Insured Employed By _____ Business Phone _____
Insurance Company _____
Insurance Company Address _____
Subscriber I.D. # _____ Group # _____

PLEASE COMPLETE REVERSE SIDE



REASON FOR VISIT

Please list your present health concerns, problems or symptoms: _____

MEDICAL HISTORY

When was your last physical exam? _____

Physician's Name _____ Phone _____

1. Are you currently under medical treatment? Yes No
 Please describe: _____

2. Have you ever had any serious illnesses or operations? Yes No
 Please describe: _____

3. Are you currently taking any medication? Yes No
 Please describe: _____

7. Have you had any allergic reactions to the following: Yes No
- | | | |
|---|--------------------------|--------------------------|
| Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates (sleeping pills) | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> |
- Please describe: _____

4. Do you smoke? Yes No
5. Do you use alcohol? Yes No
6. Do you use cocaine or other drugs? Yes No

8. Women Only: Yes No
- Do you have regular periods? Yes No
- Are you taking birth control pills? Yes No
- Have you ever been pregnant? Yes No
- Number of Pregnancies: _____

Have you ever had the following:	Yes	No		Yes	No		Yes	No
Anemia (low blood count)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia (no appetite)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problem	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis-Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency (addiction to drugs)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Cough - persistent or bloody	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Any Other Condition	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Please describe: _____		
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____		

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____