Patient Information Form

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential.

Date _____ Patient name _____
First Middle Initial Last Name
Birthdate _____ Male □ Female □ Social Security # _____ ____ _____
Address _____ City _____ State _____ Zip _____
Home phone _____ Cell Phone _____
Check the appropriate box: Minor □ Single □ Married □ Separated □ Divorced □ Widowed □
Patient's or parent's employer _____ Work Phone _____
Person to contact in case of emergency _____ Phone _____

Insurance Information

Name of Insured _____ Relationship to patient _____ Insurance I.D.# _____
Name of Employer _____ Work Phone _____
Insurance Company _____ Insurance Company Group # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Insurance Company Phone No. (on insurance card) _____

Medical History

1. Past or current history and/or treatment of: [Check all of the conditions that apply] *or* **None** □

_ Stroke	_ Seizures	_ Migraines	_ Liver Damage	_ Thyroid Problems
_ Anemia	_ Diabetes	_ Chronic Pain	_ Chronic Fatigue	_ Urinary Tract Infections
_ Asthma	_ Hepatitis	_ Tuberculosis	_ Eating Disorder	_ Persistent Flu-like Symptoms
_ Cancer	_ Hypertension	_ Allergies	_ Cardiac Problems	_ Communicable Diseases

2. Drug Allergies:
_____

3. Current Medications:
_____

4. Chemical Use History: (Include substances used, age of onset, history and current use or denial of chemical history)
_____

5. Physical exam in the last year? Yes □ No □ Name of Primary Care Physician _____

6. Pharmacy: Name _____ Phone Number _____

Authorization and Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____
Signature of patient (or parent if minor) Date

Please mail the completed form to: Dr. J. Keyser, 382 Springfield Avenue Suite 412, Summit, NJ 07901.