HEALTH HISTORY

Have you ever had: (if yes, please check)

_____ heart problems	_____ high blood pressure	_____ breathing problems
_____ psychiatric problems	_____ seizures	_____ sexual difficulties
_____ chronic fatigue	_____ visual problems	_____ hearing problems
_____ high fever	_____ nightmares	_____ diabetes
_____ amnesia/memory problems	_____ arthritis	_____ epilepsy
_____ venereal disease	_____ sweating	_____ dizziness
_____ head or spine injury	_____ frequent urination	_____ skin problems
_____ migraine headaches	_____ tension headaches	_____ abortion
_____ anxiety	_____ bed wetting	_____ eating difficulty
_____ severe menstrual cramps	_____ "female problems"	_____ allergies
_____ cancer	_____ sleep difficulty	_____ diarrhea
_____ weight problems	_____ back problems	_____ drug abuse
_____ asthma	_____ alcohol abuse	_____ ulcer
_____ blackouts	_____ physical abuse	_____ OTHER

What type of illness, disease, injury or other medical problems do you have at this time.

List all surgeries or hospitalizations you have had and approximate dates.

List any medications you are presently taking (include non-prescription).

Method of payment will be:

_____**CHECK / CASH**

MICHAEL D. EASTRIDGE, PhD, ABPP

275 96th Avenue N Suite #3 St Petersburg, Fl 33702

Name _____ Home Phone_____

Address _____ Cell Phone _____

City, State, Zip _____ Date of Birth _____

Driver's License # _____ Age _____

Social Security # _____ Sex _____Race/Ethnic ID _____

Education (Highest Level Attained) _____ Marital Status S M W D

Employer's Name and Address _____

Position _____How may years? _____

Insured through Employer's Health Plan? Yes ___ No___ Condition related to Employment Yes ___No ___

Reason for coming in? _____

Referred by _____

Names of other physicians you are currently being treated by _____

_____

If you are currently being represented by an attorney, please give his/her name, address & telephone #

_____

I would prefer to communicate via Email ____ or Text ____
If so, Please give email address or phone # _____

I understand that the doctor cannot protect my confidentiality from information on my computer or phone. I give permission to utilize this/these contact methods, with that understanding _____init _____date

I understand I am responsible for the timely payment of any fees for services provided to me by Dr Michael Eastridge or his associates. I further understand that Dr. Eastridge's office bills my primary insurance as a courtesy to me. I understand that Dr. Eastridge's office will not bill my secondary insurance. If, for any reason, my insurance does not pay the ful amount, I agree to pay the remainder of my account within 30 days of receiving a bill. I understand that overdue and/or delinquent accounts are charged interest at a rate of 18% per year. I also understand that delinquent accounts will be handled by a collection agency and I may forfeit my rights to confidentiality if my account is handed by an outside agency.

_____ _____

Patient's Signature Date