PATIENT PROFILE

PATIENT INFORMATION:

Name: _____ **Date of Birth:** _____

Marital Status: Please Check One [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Address: _____ **City:** _____ **Zip:** _____

Home#: _____ **Cell#:** _____

Message#: _____ **Social Security#:** _____

Name of Primary Physician,
Address & City: _____

PATIENT EMPLOYMENT:

[ ] Employed [ ] Unemployed [ ] Retired [ ] Student [ ] Disabled

Place of Employment: _____ Phone #: _____

RESPONSIBLE PARTY:

[ ] Please check if same as patient

Name: _____ Date of Birth: _____

Address:_____ City: _____ Zip: _____

Home#: _____ Cell#: _____

Place of Employment : _____ Phone#: _____

Social Security#: _____ Relationship to Patient:_____

EMERGENCY CONTACT:

Name: _____ Phone#: _____ Relationship: _____

PRIMARY INSURANCE:

[ ] Same as Patient [ ] Same as Responsible Party [ ] Other

Name of Insured: _____ Relationship to Patient: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Social Security#: _____

Place of Employment: _____ Phone#: _____

SECONDARY INSURANCE:

[ ] Same as Patient [ ] Same as Responsible Party [ ] Other

Name of Insured: _____ Relationship to Patient: _____

Address: _____ City: _____ Zip: _____

Date of Birth: _____ Social Security#: _____

Place of Employment: _____ Phone#: _____

Mark E. Reader, D.O.

PATIENT HEALTH HISTORY

Patient Name _____ Date of Birth _____

Primary Care Physician _____ Referring Physician _____

Preferred Pharmacy _____

Race (Mark Only One)
Decline to State☐ American Indian or Alaskan Native☐ Native Hawaiian or Pacific Islander☐ Asian☐
Black or African American☐ White☐ Some other Race☐

Ethnicity (Mark Only One)
Decline to State☐ Hispanic or Latino☐ Not Hispanic or Latino☐

Preferred Language (Mark Only One)
English☐ Spanish☐

(TAB 1) Are you taking **ANY** kind of medication now?
(This includes prescription, over the counter or herbal medication ☐ Yes ☐ No If Yes, please list below:

Name of Medication	Dosage	# of pills or amt taken per time	How often – 1, 2, 3 times/day

(TAB 2) Are you **allergic** to any medication? ☐Yes ☐No If Yes, please list below:

Name of Medication	Reaction

(TAB 5/6/7) SURGERIES AND/OR HOSPITALIZATIONS

Have you had any surgeries before? ☐ Yes ☐ No
If Yes, list any **surgeries** that you have had and the date of the procedure:

_____
_____
_____
_____
_____

Have you ever been **hospitalized** for a medical problem before? ☐ Yes ☐ No
If Yes, list hospitalizations, the reason for admission, and date:

_____
_____

Have you ever had any problems with anesthesia (being numbed or put to sleep)? ☐ Yes ☐ No
If Yes, please list what sort of problems:

_____

WHAT IS THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY?

_____

MARK E. READER, D.O.

Please read and initial after each section.

Signature on File/Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled to Mark E. Reader, DO. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Mark E. Reader. I hereby authorize Dr. Reader to 1) release any information necessary to insurance carriers regarding my illness and treatments; 2) process insurance claims generated in the course of examination or treatment; and 3) allow a photocopy of my signature to be used to process insurance claims. Dr. Reader is authorized to discuss this case with my other doctors, family members and anyone that we might need to speak with, write to, electronically transmit to or otherwise communicate with now or any time in the future. This order will remain in effect until revoked by me in writing. **_____ (initial)**

Acknowledgement of Receipt of Notice of Privacy Practice

I acknowledge that I have received a copy of the Privacy Practices of Dr. Mark E. Reader. This notice describes how the aforementioned may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. **_____ (initial)**

Office Billing and Payment Policy

I have read and understand the Office Billing and Payment Policy of Mark E. Reader, DO. I understand and accept the responsibility for any payment that might become due on my account. **_____ (initial)**

I have read and understand the above practices of Mark E. Reader, DO. My signature below signifies my consent for Dr. Reader to bill and receive payments from my insurance, my acknowledgement of the notice of privacy practices of this office, and my agreement to abide by the Billing and Payment Policy of Mark E. Reader, DO.

Printed Name of Patient: _____

_____ _____

Patient's Signature or Signature of Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

Patient Health History

Marking Instructions

- Use only a number 2 pencil.
- Fill in the complete oval as shown below.

Correct Mark ● Incorrect Marks ⊘ ✓ ✗

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DIRECTION OF FEED

Name: _____

Date of Appt: _____

1. Are you allergic to any of the following?

	Yes		Yes
Seafood	○	Metal	○
Iodine	○	Tape	○
Latex	○	Contrast Dye	○

2. Mark if you have been diagnosed with any of the following:

	Yes		Yes
Breast Cancer	○	Gastrointestinal Reflux	○
Lung Cancer	○	Hepatitis	○
Prostate Cancer	○	Stomach Ulcer	○
Skin Cancer	○		
Throat Cancer	○		
Other Cancer	○	Are you pregnant?	○
		Prostate Enlargement	○
Migraine Headache	○	Renal Failure	○
Cataracts	○	Stroke	○
Glaucoma	○		
		Anxiety	○
Nasal Allergies	○	Depression	○
Sleep Apnea	○	Diabetes	○
		Thyroid Dysfunction	○
Blood Clots/DVT	○		
High/Elevated Cholesterol	○	Anemia	○
Heart Attack	○	Hemophilia/Bleeding Disorders	○
High Blood Pressure	○		
		HIV	○
Asthma	○		
Chronic Bronchitis	○		
Emphysema	○		
Tuberculosis	○		

3. Mark family members who have been diagnosed with any of the following:

	None	Mother	Father	Brother	Sister
Problems with Anesthesia	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Thyroid Cancer	○	○	○	○	○
Unspecified Cancer	○	○	○	○	○
Hearing Loss after age 20	○	○	○	○	○
Hearing Loss before age 20	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
Asthma	○	○	○	○	○
Stroke	○	○	○	○	○
Diabetes	○	○	○	○	○
Bleeding/Clotting Problem	○	○	○	○	○

4. Mark if retired. Yes ○

5. Tobacco Use: Present

Mark your tobacco use

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoke in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Tobacco Use: In the Past but no longer using

○ None ○ Cigarettes
○ Smokeless Tobacco ○ Cigars

Give the closest amount of cigarettes you smoked in an average day.

○ 1/2 pack ○ 2 packs
○ 1 pack ○ 3 packs
○ 1 1/2 packs

Alcoholic Beverages - *A drink is 1 shot of liquor or 1 glass of wine or 1 bottle/can of beer.*

○ Less than 12 drinks/yr
○ 1-13 drinks/mo
○ 4-14 drinks/wk
○ >2 drinks/day

6. Mark if you use drugs recreationally. Yes ○

7. Caffeine Use (coffee, tea, chocolate, cola, other caffeinated drinks):

○ None ○ 2-3 per day
○ 1 per day ○ 4 or more

8. Are you exposed to second hand smoke? Yes ○ No ○

9. Mark if patient attends daycare. Yes ○

10. Will you accept transfusion of blood products if necessary? Yes ○ No ○

11. Home Living Situation (mark all that apply).

○ Alone ○ With spouse
○ With children ○ In nursing home
○ With mother ○ With father
○ In assisted living ○ Other

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12. Do you now have or have you recently had any of the following?

	Yes	No
fever	○	○
sleeping problems	○	○
unintentional weight gain	○	○
unintentional weight loss	○	○
blurred vision	○	○
itchy eyes	○	○
loss of vision	○	○
painful eye	○	○
dizziness	○	○
ear drainage	○	○
hearing loss	○	○
ear pain	○	○
ringing in the ears	○	○
nasal congestion	○	○
frequent nosebleeds	○	○
post-nasal drainage	○	○
belching sour material into throat	○	○
hoarseness or other voice changes	○	○
mouth ulcers	○	○
partials or dentures	○	○
blacking out or fainting	○	○
chest pain	○	○
heart murmur	○	○
irregular heartbeats	○	○
leg cramps	○	○
swelling of ankles	○	○
frequent non-productive cough	○	○
frequent productive cough	○	○
coughing up blood	○	○
shortness of breath	○	○
snoring	○	○
wheezing	○	○
bedwetting	○	○
urinating excessive amounts	○	○
abdominal pain	○	○
diarrhea	○	○
heartburn	○	○
nausea	○	○
trouble swallowing	○	○
painful swallowing	○	○
vomiting	○	○
painful joints	○	○
stiffness in joints	○	○
swelling of joints	○	○

12. Do you now have or have you recently had any of the following? *(continued)*

	Yes	No
moles that have changed	○	○
poor wound healing	○	○
skin lesions (suspicious)	○	○
change of smell	○	○
change of taste	○	○
drooping on one side of the face	○	○
headache	○	○
numbness	○	○
severe face pain	○	○
seizures	○	○
tremor	○	○
appetite is increased	○	○
fatigue	○	○
feels hot when others do not	○	○
feels cold when others do not	○	○
thirst is increased	○	○
bleeds excessively after injury	○	○
bruises easily	○	○
masses (lumps) in neck	○	○
food intolerance	○	○
hives	○	○
reaction to insect bites or stings	○	○
sneezing	○	○

Thank you

for

completing

this

questionnaire!