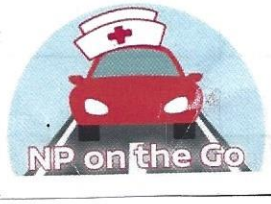


Patient Information

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Driver's License: _____ SSN: _____

Home Phone: _____ Cell: _____

Address: _____

Employer: _____ Position: _____

Employer Address: _____ Phone No. _____

Emergency Contact Information

Dependent? _____ If yes, Guardian's Name: _____

Guardian's Phone: _____ Cell: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone No. _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Insurance

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Phone No. _____

Address: _____

Policy No. _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company: _____

Insured Party: _____ Relationship to Patient: _____

Phone No. _____ Address: _____

Policy No. _____ Group No. _____

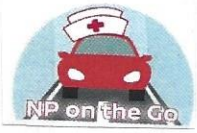
Payment Method: _____ Card/Check No. _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ _____

Patient Date



MEDICAL HISTORY

Current Physician Name/Number: _____ (___) ___-____
Current Pharmacy Name/Number: _____ (___) ___-____

CURRENT/PAST MEDICATIONS

name	dose	frequency	starting	ending	physician	purpose

SURGICAL PROCEDURES

date	procedure	physician	hospital	notes

MAJOR ILLNESSES

illness	start	end	physician	treatment notes

VACCINATIONS

name	date	name	date
tetanus		meningitis	
influenza vaccine		yellow fever	
Zostavax		polio	
other vaccine		other vaccine	

ADULT HEALTH HISTORY

Date _____

Name _____

Date of birth _____ Age _____

General health _____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
☐	☐	Asthma	
☐	☐	Bleeding disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/sinus	
☐	☐	Fainting	
☐	☐	Gastro-intestinal problems	
☐	☐	Heart disease	
☐	☐	Kidney disease	
☐	☐	Learning disorders	
☐	☐	Menstrual problems	
☐	☐	Musculo-skeletal	
☐	☐	Psychological/psychiatric	
☐	☐	Seizures	
☐	☐	Sickle cell disease	
☐	☐	Sleep disorders	
☐	☐	Stroke	
☐	☐	Surgery	
☐	☐	Thyroid disease	
☐	☐	Serious injury	
☐	☐	Other	

Allergies

Signature _____