REASON FOR VISIT

Please list your present health concerns, problems or symptoms _____

_____

_____

When was your last physical exam? _____

Physician's Name _____ Phone _____

	Yes	No
1. Are you currently under medical treatment?	❑	❑
Please describe: _____		
2. Have you ever had any serious illnesses or operations?	❑	❑
Please describe: _____		
3. Are you currently taking any medication?	❑	❑
Please describe: _____		
4. Do you smoke?	❑	❑
5. Do you use alcohol?	❑	❑
6. Do you use cocaine or other drugs?	❑	❑

7. Have you had any allergic reactions to the following:	Yes	No
Local Anesthetics (eg. novocaine)	❑	❑
Penicillin or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates (sleeping pills)	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Other	❑	❑
Please describe: _____		

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

Have you ever had the following:	Yes	No
Anemia (low blood count)	❑	❑
Anorexia (no appetite)	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Back Problems	❑	❑
Bleeding Tendency	❑	❑
Blood Disease	❑	❑
Cancer	❑	❑
Chemical Dependency (Addiction to drugs)	❑	❑
Chemotherapy	❑	❑
Chicken Pox	❑	❑
Chronic Fatigue Syndrome	❑	❑
Circulatory Problems	❑	❑
Congenital Heart Lesions	❑	❑
Cough - persistent or bloody	❑	❑
Diabetes	❑	❑
Emphysema	❑	❑
Epilepsy	❑	❑
Glaucoma	❑	❑

	Yes	No
Heart Murmur	❑	❑
Heart Disease	❑	❑
Hepatitis-Type ____	❑	❑
Hernia	❑	❑
Herpes	❑	❑
High Blood Pressure	❑	❑
HIV/AIDS	❑	❑
Jaundice	❑	❑
Kidney Disease	❑	❑
Latex Sensitivity	❑	❑
Liver Disease	❑	❑
Low Blood Pressure	❑	❑
Measles	❑	❑
Migraine Headaches	❑	❑
Mitral Valve Prolapse	❑	❑
Mumps	❑	❑
Multiple Sclerosis	❑	❑
Pacemaker	❑	❑
Pneumonia	❑	❑

	Yes	No
Polio	❑	❑
Prostate Problem	❑	❑
Psychiatric Care	❑	❑
Respiratory Disease	❑	❑
Rheumatic Fever	❑	❑
Scarlet Fever	❑	❑
Shortness of Breath	❑	❑
Sinus Trouble	❑	❑
Skin Rash	❑	❑
Stroke	❑	❑
Thyroid Problems	❑	❑
Tonsillitis	❑	❑
Tuberculosis	❑	❑
Ulcer	❑	❑
Venereal Disease	❑	❑
Any Other Condition	❑	❑
Please describe: _____		

MEDICAL HISTORY

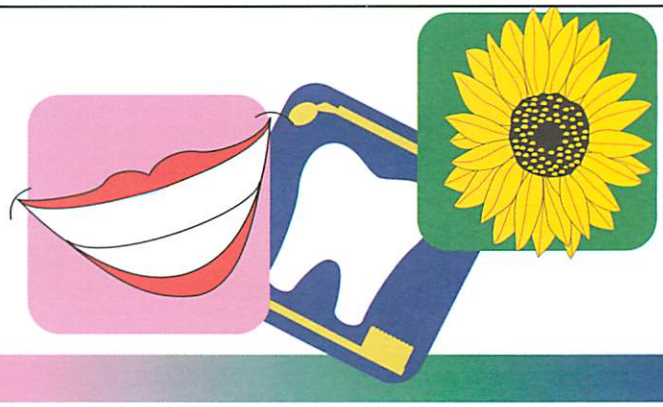
I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

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 _____

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 _____
Last Name First Name Initial

Address _____ Home Phone _____

City _____ State _____ Zip _____

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 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 Address _____

Subscriber I.D. # _____ Group # _____

PLEASE COMPLETE REVERSE SIDE