Patient Information: Primary Language: _____

First Name: _____Last Name: _____MI:_____DOB:_____

Home Phone: _____Cell:_____SSN#:_____

Home address: _____

City: _____State:_____Zip:_____

Email: _____

Employer: _____Work #:_____Occupation:_____

Employer Address: _____City:_____State:_____Zip:_____

May we contact you at work? YES NO

Family Information

Marital status Single Married Divorced Separated Widowed

Spouse's Name: _____Parent/Guardian (if minor) _____

Spouse/Parent/Guardian Employer: _____Work#:_____

Employer Address: _____City:_____ST:_____Zip:_____

Health Insurance

Name of Insured: _____DOB:_____SSN#:_____

Primary Insurance: _____

Policy/ID#:_____GRP#:_____

Secondary Insurance: _____

Policy/ID#:_____GRP#:_____

Emergency Contact:

First Name: _____Last Name: _____Phone:_____

First Name: _____Last Name: _____Phone:_____

Preferred Pharmacy:

Pharmacy: _____City:_____

Medications:

Are you presently taking any medications? YES No

If yes please list medication, dosage, and how many times a day.

Do you have allergies? YES NO

If so, Please List:_____

_____

_____

Are you under the care of another provider? If so please list Provider Name and reason.

_____

_____

Surgeries/Hospitalizations: Have you had any surgeries or hospitalizations in your lifetime? If so please list:

SURGERY/HOSPITALIZATION/PROCEDURE	WHEN?

Medical History:

- ○ Anemia/low iron count
- ○ Arthritis/joint problems
- ○ Asthma/breathing issues
- ○ HIV/blood disorders
- ○ Blood transfusion
- ○ Cancer
- ○ Other_____
  _____
- ○ Cardiac pacemaker
- ○ Diabetes
- ○ Epilepsy/seizures
- ○ Glaucoma
- ○ Heart murmur/arrhythmias
- ○ Heart attack
- ○ Hepatitis
- ○ High blood pressure
- ○ Jaundice
- ○ Kidney problems
- ○ Psychiatric/depression
- ○ Rheumatic fever
- ○ Std
- ○ Sinus/snoring
- ○ Stroke
- ○ Tuberculosis
- ○ Ulcers/heartburn

Do you consume Alcohol? YES NO How many drinks per week_____

Do you smoke? YES NO How many packs per day_____ For how many years?_____Quit? YES NO

Do you consume illicit drugs? YES NO

Any other serious illness or concer?_____

_____

_____

Signature of Responsible Party:_____Date:_____