

PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Patient Name: _____ Date: _____

Wishes to be called _____ SSN: _____

Birth Date: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Check appropriate box: Minor Single Married Divorced Widowed Separated

Patient/Parent's employer: _____ Work phone: _____

Business address: _____ City: _____ State: _____ Zip: _____

Spouse/Parent's name: _____ Employer: _____ Work phone: _____

If patient is a student, name of school/college: _____ City: _____ State: _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone: _____

In case of a medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

Parent or guardian signature: _____ Date: _____

Responsible Party (if other than patient)

Name of person responsible for this account: _____

Relationship to patient: _____ Address: _____

Home phone: _____ Birth date: _____ Driver's license: _____

Employer: _____ Work phone: _____

Is this person currently a patient at our office? Yes No

Phone Calls

Where do you prefer to receive phone calls? Home Work Cell phone

Can we leave a message? On home voice mail/answering machine _____

On work voice mail/answering machine _____

I authorize the release of my medical information to: _____

Signature of Patient _____ Date: _____

Primary Health Insurance Information

Insurance company: _____ Local/Union Name: _____

Group#: _____ ID#: _____ Name of Policy Holder: _____

Relationship to patient: _____ Date of Birth: _____ SSN: _____

Name of employer: _____ Work phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

Do you have any additional insurance? Yes No If yes, complete the following:

Insurance company: _____ Local/Union Name: _____

Group#: _____ ID#: _____ Name of Policy Holder: _____

Relationship to patient: _____ Date of Birth: _____ SSN: _____

Name of employer: _____ Work phone: _____

Address of employer: _____ City: _____ State: _____ Zip: _____

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

Signature of patient or parent if minor _____ Date: _____

PRIMARY CARE for WOMEN

NAME: _____ DATE: _____

BIRTH DATE: _____ AGE: _____

REASON FOR TODAY'S VISIT: _____

ALLERGY TO ANY MEDICATIONS? _____ If so, what? _____

LIST YOUR MEDICATIONS (including hormones, birth control, and over the counter medications):

PLEASE CHECK ANY OF THE FOLLOWING WITH WHICH YOU HAVE BEEN DIAGNOSED:

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression/Anxiety or other |
|
 | | |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Lupus | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Other |

LIST YOUR OPERATIONS: _____ YEAR/LOCATION: _____

Do you smoke now? _____ If so, how much? _____ How many years? _____

Did you smoke in the past? _____ If so, how much? _____ How many years? _____

Do you drink alcohol? _____ If so, how much? _____ Caffeine intake: _____

Do you use non-prescription drugs? _____

Blood Transfusions? _____ Exercise? _____

Marital Status: S M W D Do you have children? _____ If so, how many? _____

Employment: In Home _____ Out of Home _____ Work Status _____

PRIMARY CARE for WOMEN

DO YOU HAVE A FAMILY HISTORY OF:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression, Anxiety |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Ovarian Cancer | _____ |

OB/GYN HISTORY:

Age of First Period: _____

Number of Pregnancies: _____ Age of Menopause: _____

Number of Children: _____ Interval between menstrual periods: _____

Number of Miscarriages: _____ Spotting between periods: _____

Number of Abortions: _____ Cramping: _____

Last Pap Smear: _____ Sexually Transmitted Infections: _____

Last Mammogram: _____ Abnormal Pap Smear: _____

Last Menstrual Period: _____ Method of Birth Control: _____

VACCINATION HISTORY:

Last Tetanus/Diphtheria: _____ Last Tuberculosis Test: _____

Hepatitis B: _____ Flu: _____

Pneumovax: _____

HAVE YOU HAD ANY OF THE FOLLOWING SYMPTOMS RECENTLY?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Post nasal Drip |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Burning with Urination | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Cough | <input type="checkbox"/> Difficulty Starting Urine | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Sputum | <input type="checkbox"/> Difficulty w/urine leaking | <input type="checkbox"/> Getting up at night to urinate |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Ankle Swelling |
| <input type="checkbox"/> Joint Stiffness | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Mouth Ulcers | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Sensitive to sunlight | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Genital Ulcers | <input type="checkbox"/> Pain in Swallowing |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fingers sensitive to cold | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Blood in Stool |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Recurrent UTI | <input type="checkbox"/> Jaw Pain/TMJ | <input type="checkbox"/> Black Stools |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Bladder/Kidney Infection | <input type="checkbox"/> Recurrent Yeast Infection |

