

PLEASE PRINT

Date _____

PATIENT INFORMATION

Name First _____ MI _____ Last _____

Address _____

City _____ State _____ Zip _____

Sex M F Birthdate _____ SS# _____

Employed by _____ Occupation _____ Single Married Widowed

Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____

Cell Phone (_____) _____ E-mail Address _____

Have we ever treated any other member of your family? Yes ___ No ___ Name(s) _____

REFERRAL SOURCE choose one

Physician - Referring Physician's Name _____ Family Friend Advertisement

Other _____

RESPONSIBLE PARTY Who is responsible for the account if different than above?

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Employed by _____ Occupation _____

Birthdate _____ SS# _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext. _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Policy Holder _____

Policy Holder _____

Date of Birth _____ SS# _____

Date of Birth _____ SS# _____

GENERAL MEDICAL HISTORY

CONDITIONS Check yes or no for conditions you currently have or have had in the past.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N | <input type="checkbox"/> Y <input type="checkbox"/> N |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Herpes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergic to Local Anesthetic | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Family History of Melanoma | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Do You Smoke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Family History of Non-Melanoma Skin Cancer | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chemical Dependency | | <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Chicken Pox | | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Colitis-Diarrhea | | <input type="checkbox"/> Prostate Problem | |

NONE ■ LIST ALL CURRENT MEDICINES

NONE ■ LIST ALLERGIES TO MEDICATIONS

_____	_____
_____	_____
_____	_____
_____	_____

I HEREBY AFFIRM THAT INFORMATION PROVIDED ABOVE IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature _____ Date _____

Thank you for your cooperation.