Name _____ Date _____

Address _____

Have you ever been hospitalized? _____ Yes _____ No

If *Yes*, please give reason / procedure:

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Other medical problems in past:

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Family Doctor: _____

Specialists: _____

Allergies: Drugs _____

Foods/Environmental: _____

Last: Tetanus Immunization:_____ Mammogram: _____

Routine Physical: _____ Pap Test: _____

Average Intake: Caffeine: _____ Alcohol: _____

Nutrasweet (aspartame): _____ Tobacco: _____

Condition(s) currently being treated for: _____

_____

_____

Primary reason for initial visit: _____

Other concerns to be addressed: _____

_____

_____

Please complete the following confidential information. Date: _____

Patient name: _____ Name to be called by: _____

Birth date: _____ Gender: M____ F____

Home address: _____ Home phone: _____

City/State/Zip+4: _____ Work phone: _____ (ext) _____

Email: _____ Cell phone: _____

Social Security #: _____ Marital status: Single __ Married __ Divorced __ Widowed __

Student? ___ No ___ Yes: Full time / part time Institution _____

Name of spouse: _____ Spouse work phone: _____

Employer: _____ Employer address: _____

If Patient is not the responsible party:

Name of responsible party: _____ Title *(Mr, Mrs, Ms, Dr)*: _____

Relationship to patient: _____ D.O.B. _____

Address: _____ Employer: _____

City/State/Zip: _____ SS #: _____

Home phone:_____ Work phone: _____

Emergency Contact Information

Name:_____ Relationship: _____ Employer:_____

Home phone: _____ Address: _____

Work phone: _____ Phone: _____

Whom can we thank for referring you to us? _____

I authorize treatment of the person named above and agree to pay all fees for such treatment. I authorize the release of any information necessary for processing insurance claims and referrals. In the event my account becomes delinquent I agree to pay ALL costs of collection including 25% collection fee, attorney fees and court costs and other costs as the Court determines proper.

Signature of responsible party: _____ Date: _____

Patient name: _____ Date: _____

Primary Insurance • Policyholder information

Insurance company: _____ Policyholder name: _____

Claims Address: _____ Relationship to patient: _____

City, State, Zip: _____ Policy Holder's S.S.#: _____

Confirmation Phone #: _____ Policyholder's birth date: _____

Effective date: _____ Policyholder's gender: Male ___ Female ___

Policy ID#: _____ Policyholder's employer: _____

Group #: _____ Policyholder's work phone: _____

Individual yearly deductible: _____ Family yearly deductible: _____ Co-pay: _____

Secondary Insurance • Policyholder information

Insurance company: _____ Policyholder name: _____

Claims Address: _____ Relationship to patient: _____

City, State, Zip: _____ Policy Holder's S.S.# _____

Confirmation Phone #: _____ Policyholder's birth date: _____

Effective date: _____ Policyholder's gender: Male ___ Female ___

Policy ID#: _____ Policyholder's employer: _____

Group #: _____ Policyholder's work phone: _____

Individual yearly deductible: _____ Family yearly deductible: _____ Co-pay: _____