

# PATIENT INFORMATION

PLEASE PRINT

DATE \_\_\_\_\_

\* **PATIENT'S FULL NAME** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Social Security No. \_\_\_\_\_ Marital Status \_\_\_\_\_

Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Employed by \_\_\_\_\_

Employer's Address \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_

Home telephone \_\_\_\_\_ Work telephone \_\_\_\_\_

**If patient is minor, name of person responsible for bill:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Home telephone \_\_\_\_\_ Work telephone \_\_\_\_\_

**INSURANCE INFORMATION (If applicable)**

When completed, please give all insurance cards and Drivers license to receptionist for copying.

Primary Insurance \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_

Family or Referring Physician (first and last name) \_\_\_\_\_

\* Insured or Authorized Person's Signature \_\_\_\_\_

\* I authorize payment of medical benefits to the attending physician or supplier for services rendered. I also authorize the release of medical records to other authorized physicians or insurance companies as it pertains to my healthcare. I also understand that if my insurance plan does not cover the services provided, I will accept full financial responsibility for services incurred.

TODAY'S DATE \_\_\_\_\_

REVIEWED: \_\_\_\_\_

For Office Use

Have you ever been diagnosed with or treated for one or more of the following? If so, please indicate date of onset.

ASTHMA _____	HIGH BLOOD PRESSURE _____
ARTHRITIS _____	TUBERCULOSIS, HEPATITIS, HIV _____
CANCER _____	DIABETES _____
THYROID _____	HEART DISEASE _____
STROKE _____	CATARACTS _____
GLAUCOMA _____	MIGRAINES _____
SEIZURES _____	OTHER _____

**Review of Symptoms**

**No Yes If YES, please explain**

Do you currently have any of the following problems:

Chronic fever, unexpected weight loss/gain, fatigue .....   \_\_\_\_\_

Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat) .....   \_\_\_\_\_

Heart problems (e.g., chest pain, irregular heartbeat) .....   \_\_\_\_\_

Respiratory problems (e.g., shortness of breath, wheezing, coughing) .....   \_\_\_\_\_

Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting) .   \_\_\_\_\_

Urinary problems (e.g., pain or discomfort, blood in urine) .....   \_\_\_\_\_

Skin problems (e.g., rashes, excessive dryness) .....   \_\_\_\_\_

Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints) .....   \_\_\_\_\_

Neurological problems (e.g., numbness, weakness, headaches, paralysis) .....   \_\_\_\_\_

Psychiatric problems (e.g., depression, anxiety) .....   \_\_\_\_\_

**Family and Social History**

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

No  Yes If YES, please explain \_\_\_\_\_

Do you smoke? If yes, how much?

Drink alcohol? If yes, how much?