

PATIENT INFORMATION

# \_\_\_\_\_

DATE \_\_\_\_\_

SS# \_\_\_\_\_

NAME \_\_\_\_\_

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

CITY \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

TELE # \_\_\_\_\_

TELE # \_\_\_\_\_

ALTERNATE TELE # \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

PRIMARY CARE DOCTOR \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

REASON FOR VISIT \_\_\_\_\_

MARITAL STATUS: S M W D SEX: M F \_\_\_\_\_

INSURANCE INFORMATION

PRIMARY INSURANCE \_\_\_\_\_ CERTIFICATE # \_\_\_\_\_

GROUP # \_\_\_\_\_ SUBSCRIBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

SECONDARY INSURANCE \_\_\_\_\_ CERTIFICATE # \_\_\_\_\_

GROUP # \_\_\_\_\_ SUBSCRIBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

PERSON RESPONSIBLE FOR PAYMENT:

\_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE

PRINT

EMERGENCY CONTACT \_\_\_\_\_ TELE # \_\_\_\_\_

DRUG ALLERGIES \_\_\_\_\_

PREFERRED PHARMACY \_\_\_\_\_

**FAILURE TO SHOW FOR A SCHEDULED APPOINTMENT WITHOUT CANCELLATION WILL RESULT IN A \$25 FEE PAYABLE PRIOR TO NEXT SCHEDULED APPOINTMENT.**

NAME \_\_\_\_\_ DATE \_\_\_\_\_ UPDATE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ lbs.

TOBACCO USE?    YES    NO    HOW LONG?                      FREQUENCY?

**PLEASE LIST ALL OF YOUR DAILY MEDICATIONS BELOW:**

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**MEDICAL HISTORY:** (Please check all that apply)

- Allergy
- Asthma
- Eczema
- Thyroid Disorders
- Hearing Loss
- Ringing in the ears (Tinnitus)
- High Blood Pressure
- Sinus Infections
- Ear Infections
- Acid Reflux (GERD)

**List any other medical history not listed:**

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**SURGICAL HISTORY:** (Please list all surgeries)

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**FAMILY HISTORY:** (Please check all that apply)

- Allergy
- Asthma
- Eczema
- Thyroid Disorders
- Hearing Loss
- Ringing in the ears (Tinnitus)
- High Blood Pressure
- Sinus Infections
- Ear Infections
- Acid Reflux (GERD)

**List any other family history not listed:**

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**PRIMARY CARE PHYSICIAN:**

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