

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:

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:

SURGICAL HISTORY: (Please list all surgeries)

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:

PRIMARY CARE PHYSICIAN:
