

This information is necessary for our files and will be considered confidential.

DATE _____

PATIENT'S NAME: _____
Last First MI (Preferred Name)

GENDER (M/F): _____ MARITAL STATUS: _____ BIRTH DATE: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ E-MAIL ADDRESS: _____

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ WORK PHONE: _____ EXT: _____ BEST TIME TO CALL: _____

FAX: _____ PAGER / CELLULAR: _____ OTHER: _____

REFERRAL INFORMATION

NAME OF PERSON, OFFICE OR OTHER SOURCE REFERRING YOU TO OUR PRACTICE: _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

PATIENT'S NAME: _____
Last First MI (Preferred Name)

GENDER (M/F): _____ MARITAL STATUS: _____ BIRTH DATE: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE #: _____ E-MAIL ADDRESS: _____

ADDRESS: _____
Street City State Zip

HOME PHONE: _____ WORK PHONE: _____ EXT: _____ BEST TIME TO CALL: _____

FAX: _____ PAGER / CELLULAR: _____ OTHER: _____

EMPLOYMENT INFORMATION

THE FOLLOWING IS FOR: THE PATIENT THE PERSON RESPONSIBLE FOR PAYMENT

EMPLOYER NAME: _____ PHONE: _____

EMPLOYER ADDRESS: _____
Street City State Zip

INSURANCE INFORMATION

Primary

NAME OF INSURED: _____
Last First MI

INSURED'S BIRTH DATE: _____ ID #: _____ GROUP #: _____

INSURED'S ADDRESS: _____
Street City State Zip

INSURED'S EMPLOYER NAME: _____
ADDRESS: _____
Street City State Zip

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE PLAN NAME: _____
ADDRESS: _____
Street City State Zip

Secondary

NAME OF INSURED: _____
Last First MI

INSURED'S BIRTH DATE: _____ ID #: _____ GROUP #: _____

INSURED'S ADDRESS: _____
Street City State Zip

INSURED'S EMPLOYER NAME: _____
ADDRESS: _____
Street City State Zip

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE PLAN NAME: _____
ADDRESS: _____
Street City State Zip

PLEASE COMPLETE REVERSE SIDE

HEALTH QUESTIONNAIRE

NAME OF PHYSICIAN _____

CITY _____

DATE OF LAST PHYSICAL _____

**PLEASE "X" EACH BOX IF THE ANSWER IS "YES", LEAVE BLANK IF "NO"
HAVE YOU HAD...**

- | | | |
|---|--|--|
| <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> RADIATION TREATMENTS | <input type="checkbox"/> MALIGNANCIES |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> TONSILS REMOVED | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> CHRONIC SINUS |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> CHRONIC EAR PROBLEMS |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> NERVOUS PROBLEMS | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> EXCESSIVE BLEEDING | <input type="checkbox"/> ADENOIDS REMOVED |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> H.T.L.V. |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> TAKEN DIET PILLS
fenfluramine/phentermine or
dexfenflurmine (Redux) | <input type="checkbox"/> H.I.V. |
| | | <input type="checkbox"/> VENEREAL DISEASE/HERPES |

OTHER HEALTH COMPLICATIONS NOT LISTED ABOVE _____

ARE YOU ALLERGIC TO

PENICILLIN

ASPIRIN

LATEX

OTHER _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

HAVE YOU BEEN UNDER THE CARE OF A PHYSICIAN IN THE LAST TWO YEARS? IF YES, PLEASE EXPLAIN: _____

PLEASE LIST ANY OTHER MEDICAL CONDITIONS YOU FEEL THE DOCTOR SHOULD BE AWARE OF: _____

HAVE YOU EVER BEEN HOSPITALIZED? YES NO IF YES, PLEASE EXPLAIN: _____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE _____

STATE RELATIONSHIP (i.e., neighbor, friend, relative) _____

SIGNATURE OF RESPONSIBLE PARTY _____

RELATIONSHIP _____

DATE _____