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PATIENT INFORMATION :

Today's Date: ______________________ Account #: ______________________

Name: ______________________ SSN: ______________________

Address: ______________________ City/State/Zip: ______________________

Primary Phone: (number you wish to be reached at) ______________________ Other #: ______________________

Date of Birth: ______________ Age: ______________ Sex: ______________

Marital Status: ______________________ Spouse's Name: ______________________

Race: ☐ Hispanic ☐ African American ☐ Caucasian ☐ Asian ☐ Other

Occupation: ______________________ Work No: ______________________

Employer: ______________________ Full Time Student: ☐ Yes ☐ No

Email: ______________________

Next of Kin: ______________ Relationship: ______________ Phone No: ______________

Who Referred you? ☐Physician ☐Family ☐Friend ☐Phone Book ☐Insurance Co. ☐Other ______________

Referring Physician's Name: ______________________ Primary Physician ______________________

Reason for visit ______________________ Pharmacy ______________________

INSURANCE INFORMATION:

Please present your insurance card(s) to the receptionist. Please give complete information.

Primary Insurance: ______________________ Insured's Name: ______________________

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: ______________________ Group#: ______________________

Employer: ______________ SSN: ______________ DOB: ______________

Secondary Insurance: ______________________ Insured's Name: ______________________

Patient's Relationship to Insured: ☐ Self ☐Spouse ☐Child ☐Other

Policy #: ______________________ Group #: ______________________

Employer: ______________ SSN: ______________ DOB: ______________

NOTICE REGARDING INSURANCE CLAIMS/PAYMENTS:

If we are filing insurance for your visit, we must have complete information and any required referral at the time of the visit. If you cannot provide the information, we will be unable to file your insurance, and payment in full will be required.

Payment of your charges cannot be determined until the claim is submitted to your insurance company. Payment will be based on your individual health plan, and the amount applied to your plan deductible and/or coinsurance will be your responsibility. Procedures which are excluded from coverage, based on your plan's determination of medical necessity, will also by your responsibility. Your office visit co-pay is due at the time of the visit and, in many cases, covers only the office visit charge. Any procedures performed will be considered surgery by your insurance company, and deductibles and coinsurance may apply.

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request.

I have read the above information and understand that I am responsible for payment for services I receive.

Patient/Guardian Signature: ______________________ **Date:** ______________

Past Medical & Social History
List all serious illnesses in your immediate family. (Example: diabetes, tuberculosis, cancer, heart disease, etc.) And please state relationship to you.

_____________________ ___________________________ _____________________
_____________________ ___________________________ _____________________

List any personal past illnesses and/or surgeries and when they occurred.

Illness or Surgery	Date	Illness or Surgery	Date

Are you on any medications? YES OR NO
If yes, please list:
____

Do you: Consume caffeinated food/drinks? YES OR NO
If yes how much?_________________________
Consume Alcohol? YES OR NO
Have a special diet?________________
If yes what kind?_________________________
Do you have any known drug allergies? YES OR NO
(If yes, list all.) ____
____
____

Smoke? YES OR NO
If yes how long/packs per day?_______

Review of Systems
Do you now or have you had any problems related to the following systems? Circle yes or No.

A. Constitutional Systems
Fever Y N
Chills Y N
Headache Y N
Other___________________

B. Eyes
Blurred Vision Y N
Double Vision Y N
Other___________________

C. Allergic/Immunologic
Hay Fever Y N
Drug Allergies Y N
Other__________________

D. Neurological
Tremors Y N
Dizzy Spells Y N
Numbness/Tingling Y N
Other__________________

H. Integumentary
Skin Rash Y N
Other__________________

I. Musculoskeletal
Joint Pain Y N
Back Pain Y N
Other__________________

J. Ear/Nose/Throat/Mouth
Sinus Problems Y N
Other__________________

K. Genitourinary-Male
Urine Retention Y N
Erectile Dysfunction Y N
Urinary Frequency Y N
Other_________________

E. Endocrine
Excessive Thirst Y N
Too Hot/Cold Y N
Tired/Sluggish Y N
Other____________________

F. Gastrointestinal

Abdominal Pain Y N
Nausea/Vomiting Y N
Other____________________

G. Cardiovascular
Heart Trouble Y N
High Blood Pressure Y N
Other____________________

L. Genitourinary-Female
Loss of Urine Y N
Painful Urination Y N
Urinary Frequency Y N
Date Last Menstrual Period:
Other_________________

M. Respiratory
Frequent Cough Y N
Shortness of Breath Y N
Other_________________

N. Hematological/Lymphatic
Swollen Glands Y N
Blood Clotting Problems Y N
Other_________________

O. Psychologic
Are you generally satisfied with your life? Y N
Do you feel severely depressed? Y N
Other_______________________

Patient Signature:____ Date:

For Physician's Use Only (4)

History Of Present Illness
*Location____
*Quality____
*Severity____
*Duration____
*Timing____
*Context____
*Motivating Factors____
*Associated Signs &
Symptoms____