PATIENT INFORMATION DATE: ___________

NAME _______________________________ BIRTHDAY_______ AGE_______ SEX: M F MARITAL STATUS M S W D

ADDRESS _____________________________ CITY_________________________ STATE____ ZIP CODE

HOME PHONE_________________________ WORK PHONE_________________ SOC. SEC.#________________________

EMPLOYER___________________________ ADDRESS_______________________________________

INSURANCE CO.______________________ I.D.#___________________________ GROUP #_____________

METHOD OF PAYMENT_______ ☐ CASH OR CHECK ☐ MASTERCARD ☐ VISA ☐ OTHER

PERSON RESPONSIBLE FOR ACCOUNT____

EMERGENCY NAME (SOMEONE WHO COULD GET A MESSAGE TO YOU IF WE NEED TO CHANGE AN APPOINTMENT AND CANNOT REACH YOU; SOMEONE WHO DOES NOT LIVE WITH YOU.____

RELATIONSHIP TO YOU_________________ CITY_____________________ PHONE#____________

WHOM ARE WE TO THANK FOR RECOMMENDING YOU TO THIS OFFICE?____

SPOUSE/GUARDIAN INFORMATION (please circle)

NAME_________________________________ ADDRESS (if different)______________________________

SOCIAL SECURITY____________________ CITY__________________________ STATE_______ ZIP________

EMPLOYER_____________________________ ADDRESS________________________________

HOME PHONE (if different) _________________________ WORK PHONE (if different) ________________________

INSURANCE CO.____________________ I.D.#_________________________ GROUP#__________________________

FAMILY DOCTOR_________________ CITY___________________________ STATE_________________________
FAMILY DENTIST_________________ CITY___________________________ STATE_________________________

CHECK "YES" OR "NO" IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

YES	NO			YES	NO			YES	NO	
		DIABETES				KIDNEY TROUBLE				VENEREAL DISEASE
		RHEUMATIC FEVER				JAUNDICE				A.I.D.S..
		HEART MURMUR				HEPATITIS				HI/LOW BLOOD PRESSURE
		TUBERCULOSIS				ANEMIA				CANCER
		HEART TROUBLE				BLEEDING PROBLEMS				STOKE
		LIVER TROUBLE				EPILEPSY				PREGNANT AT PRESENT IF YES, WHEN DUE_____
		LUNG TROUBLE				SEIZURES				
		UNUSUAL REACTION TO ANY ANESTHETIC								RADIATION TREATMENT

HAVE YOU EVER BEEN IN THE HOSPITAL OR HAD OUTPATIENT SURGERY?________ IF YES, WHAT FOR (GIVE DATES)_________

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____

____

ARE YOU ALLERGIC TO ANYTHING? IF YES, WHAT ____

ARE YOU TAKING ANY MEDICATIONS, INCLUDING BIRTH CONTROL PILLS? IF YES, WHAT _______________________

DO YOU WEAR CONTACT LENSES? IF YES, ARE YOU WEARING THEM NOW? ________________________________

OTHER MEDICAL INFORMATION ____

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