WELCOME TO OUR PRACTICE

Please Complete the Information Below to Help Us Serve You Better

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOC. SEC. # _____ BIRTHDATE _____ HOME PHONE _____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYLED _____

NAME OF EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ❑ YES ❑ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYLED _____

NAME OF EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE CO. _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

PATIENT MEDICAL HISTORY

	YES	NO
1. ARE YOU IN GOOD HEALTH	❑	❑
2. DATE OF YOUR LAST PHYSICAL EXAM _____		
3. PHYSICIAN'S NAME _____		
4. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	❑	❑
5. HAVE YO EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS	❑	❑
PLEASE EXPLAIN _____		
6. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE	❑	❑
IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____		
7. HAVE YOU HAD ANY ABNORMAL BLEEDING	❑	❑
8. DO YOU BRUISE EASILY	❑	❑
9. DO YOU USE TOBACCO	❑	❑
10. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	❑	❑

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	❑	❑
ARE YOU NURSING	❑	❑
ARE YOU TAKING BIRTH CONTROL PILLS	❑	❑

	YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:		
LOCAL ANESTHETICS LIKE NOVOCAINE	❑	❑
PENICILLIN OR OTHER ANTIBIOTICS	❑	❑
SULFA DRUGS	❑	❑
BARBITURATES, SEDATIVES OR SLEEPING PILLS	❑	❑
ASPIRIN	❑	❑
IODINE	❑	❑
ANY METALS (E.G., NICKEL, MERCURY, ETC.)	❑	❑
LATEX / RUBBER	❑	❑
OTHER (PLEASE LIST) _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	❑	❑
SCARLET FEVER	❑	❑
HEART DEFECT OR HEART MURMUR	❑	❑
HEART TROUBLE, HEART ATTACK, OR ANGINA	❑	❑
CHEST PAIN	❑	❑
SHORTNESS OF BREATH	❑	❑
PACEMAKER	❑	❑
HEART SURGERY	❑	❑
HIGH/LOW BLOOD PRESSURE	❑	❑
CONGENITAL HEART PROBLEM	❑	❑
SWELLING OF FEET, ANKLES, HANDS	❑	❑
HEPATITIS, JAUNDICE OR LIVER DISEASE	❑	❑
STROKE	❑	❑
SINUS TROUBLE	❑	❑
LUNG OR BREATHING PROBLEMS	❑	❑
ASTHMA OR HAY FEVER	❑	❑

	YES	NO
HIVES OR SKIN RASH	❑	❑
FAINTING OR DIZZY SPELLS	❑	❑
DIABETES	❑	❑
AIDS OR HIV INFECTION	❑	❑
THYROID PROBLEMS	❑	❑
ALLERGIES	❑	❑
ARTHRITIS OR RHEUMATISM	❑	❑
JOINT REPLACEMENT OR IMPLANT	❑	❑
STOMACH ULCER	❑	❑
KIDNEY TROUBLE	❑	❑
TUBERCULOSIS	❑	❑
PERSISTENT COUGH	❑	❑
COUGH THAT PRODUCES BLOOD	❑	❑
CHEMOTHERAPY (CANCER, LEUKEMIA)	❑	❑
SEXUALLY TRANSMITTED DISEASE	❑	❑
EPILEPSY OR SEIZURES	❑	❑
ANEMIA	❑	❑
GLAUCOMA	❑	❑
NERVOUSNESS	❑	❑
TONSILLITIS	❑	❑
TUMORS	❑	❑
MENTAL HEALTH CARE	❑	❑
BACK PROBLEMS	❑	❑
CHEMICAL DEPENDENCY	❑	❑
MITRAL VALVE PROLAPSE	❑	❑
CORITSONE TREATMENT	❑	❑
COLD SORES / FEVER BLISTERS	❑	❑
HYPOGLYCEMIA	❑	❑
EATING DISORDERS	❑	❑

SIGNATURE OF PATIENT OR PARENT IF MINOR _____