



\_\_\_\_\_ Clinic

**Patient Information:**

**Today's Date:**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
(City) (State) (Zip Code)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Patient Portal Access:  YES  NO

Patient SS#: \_\_\_\_\_ Sex:  M  F Single  Married  Widowed  Separated  Divorced

Patient's Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

**Spouse's Information:**

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse SS#: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

**Responsibility:**

Who is responsible for this account? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Birth date: \_\_\_\_\_ SS# \_\_\_\_\_

**Insurance Information: (Please provide copies of your insurance cards)**

Insurance Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Group Name: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Medicare \*Retirement Date: \_\_\_\_\_ \*Spouse retirement date: \_\_\_\_\_

Is patient covered by additional insurance? YES  NO  (If Yes - Please provide the same above information for the additional insurance policy):  
\_\_\_\_\_

**\*\*Payment is expected at the time of service unless prior arrangements have been made\*\***



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Parental Information: (For patients under age 18)**

Mother: _____	Father: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Who has legal custody of child? _____	

**List medications you are currently taking: (Include over the counter medications)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List allergies to medications, substances, or food:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Pharmacy:**

Name/City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Previous Physician:** \_\_\_\_\_

**Contact Information:**

Emergency Contact: _____	Phone: _____
Relationship: _____	

**Advance Directive Information:**

DO YOU HAVE ADVANCE DIRECTIVES? <b>YES</b> <b>NO</b>
If you would like information concerning advanced directives, please let us know.

Whom may we thank for referring you: \_\_\_\_\_



Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Past Medical History: (Please check all that apply)**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> COPD	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Gout
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Anemia	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Polio
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke	<input type="checkbox"/> Reflux (heartburn)	<input type="checkbox"/> Skin ulcers
<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Seizures/ Epilepsy	<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Hay Fever/allergies
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Depression
<input type="checkbox"/> Vein problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Syphilis/V.D.	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Blood clots			

Other (please specify): \_\_\_\_\_

**\*\*Immunizations/Testing: Please provide a copy of your immunization records\*\***

**Past Surgical History: (Please list all previous surgeries and dates)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family History**

**Father:** Alive \_\_\_\_\_ Deceased \_\_\_\_\_ Present health or cause of death: \_\_\_\_\_

**Mother:** Alive \_\_\_\_\_ Deceased \_\_\_\_\_ Present health or cause of death: \_\_\_\_\_

**Siblings:** #Alive \_\_\_\_\_ #Deceased \_\_\_\_\_ Present health or cause of death: \_\_\_\_\_

**Children:** #Alive \_\_\_\_\_ Ages and Health \_\_\_\_\_

#Deceased \_\_\_\_\_ Age and Cause of Death \_\_\_\_\_

Indicate any illnesses that have occurred in any of your **blood relatives: (M-maternal, P- paternal, S-Sibling)**

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Allergy
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Stroke	<input type="checkbox"/> Other: _____		

**Health Habits**

Do you/have you smoked? \_\_\_\_\_ How many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you/have you used chewing tobacco? \_\_\_\_\_ How much? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How much? \_\_\_\_\_

Do you use any illicit drugs? \_\_\_\_\_ What? \_\_\_\_\_ How much? \_\_\_\_\_

Do you exercise on a regular basis? \_\_\_\_\_ What do you do? \_\_\_\_\_

Do you follow any specific diet? \_\_\_\_\_ What is the diet? \_\_\_\_\_

Have you traveled out of the country in the last three months? **Yes No**

If yes please list country/countries: \_\_\_\_\_

**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_