Patient Information **Date:** _____

Last Name:_____ _First Name: _____ MI: ____

Address: _____ _____

City: _____ _____ _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____Work: _____

Email: _____ _____ ____Preferred Method of Contact_____

SSN: _____-_____-_____ DOB: ____/_____/_____ Age: ____ ____

Employment Status: _____ _____Employer: _____

Reason for Visit: _____ Whom may we thank for referring you? _____
Is your visit due to a job related injury or auto accident? Y_____ N_____
If yes: Date of Injury/Accident: _____/_____/_____

Gender: Male / Female **Marital Status**: Single/ Married/ Widowed/ Divorced/ Separated

Race: circle one: White/ Black/African American /Asian/ Amer. Indian or Alaska Native/ Native Hawaiian or Other Pacific Islander/ Other

Ethnicity: White/ Black/African American/ Asian/ Hispanic/Latino/Spanish **Preferred Language**:_____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ ____Cell Phone: _____Work Phone: _____

Smoking: Current smoker: _____ Yrs. Smoked _____Former smoker _____ Never smoked_____

Primary Doctor or Referring Physician: _____ **Date Last Seen PCP**: ____/____/_____

Medical Information
Pharmacy Name: _____Town_____
Medications & Dosages:

_____

_____

_____

Allergies:
Adhesive Tape___ Codeine___ Ibuprofen___ Local Anesthetics ___ Demerol___ Aspirin ___
Sulfa Drugs ___ Penicillin___ Iodine___ Anticoagulant Therapy ___ Sea Food_____ Nuts ____ Latex ___
Other_____

History:
Past Surgery (ies) with dates: _____

_____

_____

Please check Yes or No

AIDS/HIV	Yes__ No__	Diabetes	Yes__ No__	Plantar Warts	Yes__ No__
Allergies to Anesthetics	Yes__ No__	Ear Problems	Yes__ No__	Psychiatric Care	Yes__ No__
Anemia	Yes__ No__	Epilepsy	Yes__ No__	Radiation Treatment	Yes__ No__
Ankle pain	Yes__ No__	Eye Problem	Yes__ No__	Phlebitis	Yes__ No__
Arthritis	Yes__ No__	Fainting	Yes__ No__	Respiratory Disease	Yes__ No__
Athlete's Foot	Yes__ No__	Flat Feet	Yes__ No__	Rheumatic Fever	Yes__ No__
Artificial Heart Valves/Joints	Yes__ No__	Foot/Leg Cramps	Yes__ No__	Shortness of Breath	Yes__ No__
Asthma	Yes__ No__	Gout	Yes__ No__	Sinus Problems	Yes__ No__
Back Problems	Yes__ No__	Headaches	Yes__ No__	Special Diet	Yes__ No__
Heart Disease	Yes__ No__	Stroke	Yes__ No__	Neuropathy	Yes__ No__
Heel Pain	Yes__ No__	Swelling Ankles	Yes__ No__	Numbness in Feet/Legs	Yes__ No__
Bleeding Disorders	Yes__ No__	Hemophilia	Yes__ No__	Swollen Neck Glands	Yes__ No__
Bunions	Yes__ No__	Hepatitis/Jaundice	Yes__ No__	Tuberculosis	Yes__ No__
Cancer	Yes__ No__	High Blood Pressure	Yes__ No__	Ulcers	Yes__ No__
Chemical Dependency	Yes__ No__	Ingrown Toenails	Yes__ No__	Corns & Calluses	Yes__ No__
Chest Pain	Yes__ No__	Kidney Problems	Yes__ No__	Varicose Veins	Yes__ No__
Chronic Diarrhea	Yes__ No__	Liver Disease	Yes__ No__	Thyroid Disease	Yes__ No__
Circulatory Problems	Yes__ No__	Low Blood Pressure	Yes__ No__	Weight Loss, Unexplained	Yes__ No__

Other Know Illnesses: _____

_____

Has any **family member** had any of the following (please indicate relationship)

Diabetes: _____ Cancer: _____

Heart Disease: _____ High Blood Pressure: _____

Kidney Disease: _____ Stroke: _____

Arthritis: _____ Blood Clots: _____

Other: _____

Is there any other information you would like us to be aware of: _____Yes _____No

Please describe: _____

_____

_____

Insurance Information:

Primary Insurance
Insurance Company: _____ ID#_____
Insured: SELF_____ IF NOT:

Subscriber's Name: _____ _____DOB: _____
Relationship to Patient_____
Address: _____ City_____ State _____ Zip Code _____

Secondary Insurance
Insurance Company: _____ ID#_____
Insured: SELF_____ IF NOT:

Subscriber's Name: _____ DOB: _____
Relationship to Patient_____
Address: _____ City_____ State _____ Zip Code _____

Insurance Authorization and Assignment

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/INSURANCE COMPANY BENEFITS BE MADE TO DR _____ FOR ANY SERVICE FURNISHED ME BY THAT PHYSICIAN. I AUTHORIZE HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CMS AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE TO RELATED SERVICES.
I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM IN MEDICARE OR INSURANCE COMPANY ASSIGEDCASED, THE PHYSICIAN AGREES TO ACCEPT THE CHARGE DETERMINED BY MEDICARE OR MY INSURANCE COMPANY AS PAYMENT IN FULL. I AM RESPONSIBLE FOR ANY DEDUCTIBLE, COINSURANCE, OR NON-COVERED SERVICES.

SIGNATURE: _____ DATE: _____

Your health information will be kept confidential. Any information we collect about you on this form will be kept confidential in our office. Your health information will be shared with insurance carriers for billing purposes only.