Patient Information Form

*Please provide copy of insurance card front and back

PLEASE PRINT ALL INFORMATION CLEARLY

Last Name: ______________________________

First Name: ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

Home Tel #: ____________ Work Tel # ____________

Birth Date: ____________ Social Security #: ____________

Sex: ____________ Marital Status ____________

Emergency Contact: ____________ Phone#: ____________

Reason for Visit: ______________________________

Primary Physician: ______________________________

Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

Tele # ______________________________

Referring Physician: ____________ Tel: ____________

Address: ______________________________

City: ____________ State: ____________ Zip Code: ____________

Primary Insurance: ______________________________

Policy/Group # ____________ I.D.# ____________

Relationship to Insured (self, child, spouse, other): ____________

Name of Insured Party: ____________ Birth Date: ____________

Social Security# ____________ Co-Pay: ____________

Secondary Insurance: ______________________________

Policy/Group # ____________ I.D.# ____________

Relationship to Insured (self, child, spouse, other): ____________

Name of Insured Party: ____________ Birth Date: ____________

Social Security # ____________ Co-Pay ____________

CONSULTATION FORM

Medical problems:

Coronary heart disease ______ Diabetes _____ High blood pressure ______ Cancer (specify) _____

Low blood pressure ________ Previous major surgery (specify) ____________________________

Do you have religious objections to blood transfusion? ____________________________

Have you ever received blood transfusion? Yes _____ No _____ If Yes When? _________

Are you taking any medications regularly?

Medication	Name of Medication	Dosage
_______Aspirin	____________	____________
_______Digitalis (Lanoxin)	____________	____________
_______Insulin	____________	____________
_______Steroid	____________	____________
_______Anti-seizure	____________	____________
_______Diuretic	____________	____________
_______ Antidepressant	____________	____________
_______Blood Thinner	____________	____________
_______Other cardiac medication	____________	____________

Other medications:____

Allergies and Sensitivities:____________________________________

Reaction: ____

Family History:

Mother: Living _____ Age? ____ Deceased ____ Age at death? _____ Cause of death _______

Father: Living _____ Age? ____ Deceased ____ Age at death? _____ Cause of death _______

Any family history of:

Cancer ______ Diabetes ______ Tuberculosis ______ Alcoholism ______Heart disease ______

High blood pressure ______ Neurological disease ______ Psychiatric illness ______ Stroke ______

Blood clot ______ High cholesterol ______ Kidney disease______ Thyroid disease ______

Breast cancer ______

Occupation and name of employer: ______________________________

Tobacco? Yes ________ # of years ______Never ______ Stopped ______ How long ago? ______

Alcohol: Yes ____ Beer ____Wine ____ Liquor ____ Never ____ Average drinks/week ____

Stopped: Yes ____ No ______ How long ago ______

Do you exercise? Yes ____ No ____ How often? ______________________

Have you had any of the following? Check the ones that apply.

________Recent gain or loss of weight
________Unusually severe headaches
________Persistent fever, chills or night sweats
________Glaucoma
________Tightness, pressure, or pain in the chest
________Racing or skipping heart beats
________History of mitral-valve prolapse
________Persistent swelling of feet or ankles
________Blood in the stool, or black stool
________Ulcers, gall bladder disease, or hepatitis
________Stiffness, pain or swelling in any joints
________Seizures, fainting or blackouts
________Problems with coordination or speech
________Easy bruising or excessive bleeding
________Blood clot in the leg or lung
________Psychiatric illness
________Pain in the calf while walking
________Treatment of skin rashes, cancer or unusual moles
________Sudden vision loss, blurry vision
________Ear, nose or throat problems
________Shortness of breath, wheezing
________Persistent coughing up blood
________Pneumonia, emphysema
________Any other lung problems
________Loss of appetite
________Stomach pain
________Persistent nausea or vomiting
________Heart burn
________Difficulty starting or stopping urination
________Weakness, numbness or tingling in arm or legs
________Multiple sclerosis, Parkinson's disease or stroke
________Any unusual vaginal bleeding

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read the notice carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling or writing *the privacy officer.*

Date: ____

*Signature:____

*As the representative of the above individual, I acknowledge the receipt of the Notice on his or her behalf.

Date:____

Signature: ____

Relationship:____