□ New Patient □ Established Patient Date _____/_____/ _____

Patient Information

Last Name: _____ First Name: _____ Middle Initial:_____

Address: _____City:_____ State:_____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address:_____ Marital Status:_____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: □ Male □ Female

Emergency Contact

Last Name: _____ First Name: _____ Middle Initial:_____

Address:_____ City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address:_____ Relationship:_____

Insurance Information

What is the name of your insurance provider? □ Medicare □ Medicaid □ BC/BS □ Tricare

Other (Please specify) _____ Effective Date: _____/_____/_____

Name of Policy Holder: Last Name: _____ First Name: _____ Middle Initial: ____

Relationship to Patient:_____ Social Security Number of Policy Holder:_____-_____-_____

Address of Policy Holder City:_____ State:_____ Zip:_____

Policy Holder's Phone:_____ Insurance Identification Number_____

Group Identification Number: _____

Employment

Status: □ Retired □ Full-Time □ Part-Time □ Unemployed Other:_____

Name of Employer:_____ Occupation:_____

City:_____ State:_____ Zip:_____

Advanced Directives

Date Reviewed:____/____/_____ □ None □ DNR □ Living Will □ Durable Power of Attorney

□ Other (Please Specify) _____

Relationship: _____ Home Phone: _____

Last Name: _____ Work Phone: _____

First Name: _____ Effective date of representation:_____

Address: _____ Duration of representation: _____ □ Indefinitely

City: _____ State: _____ Zip: _____

History

Do you have any of these medical problems? If **YES** please circle.

Eyes	- cataracts, glaucoma, glasses/contacts, macular degeneration, other _____
Ear, Nose & Throat	- allergies, sinusitis, dental abscess, swollen glands, chronic sore throat, TMJ
Heart	- high blood pressure, irregular heartbeat, heart failure, heart attack, CAD
Lungs	- asthma, emphysema, COPD, pneumonia, sleep apnea, cancer
Stomach & Intestines	- reflux, ulcers, irritable bowel, diverticulosis, constipation, cancer
Urinary	- urine incontinence, prostate disease, sexually transmitted disease, kidney stones
Muscles & Joints	- arthritis, pain in arms/legs/neck/back, radiating pain
Brain & Nerves	- seizures, headache, migraines, stroke, Parkinsonism, dementia
Skin	- acne, eczema, psoriasis, hives, cancer, other: _____
Hormones	- diabetes, thyroid, high cholesterol, menopausal, osteoporosis, gout
Blood	- anemia, bleeding, blood clots, cancer
Psychiatric	- depression, anxiety, bipolar, schizophrenia, other: _____

Please list any other medical issues you have currently not listed above_____
_____
_____
_____

Have you had any surgeries? If YES, please list below

Surgery	Age	Physician	Year

Please list other physicians who provide care for you:

_____

_____

Are you currently taking any medicines? If **YES** please write them below, or provide a current list

Name of Medication	Medicine dosage	How many times each day?	For what condition?

Are you allergic to any medications? If **YES** please write them below.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Family's Medical History

	Mother	Father	Sister	Brother	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father
Alcoholism								
Anxiety								
Arthritis								
Asthma								
Cancer & Type								
Depression								
Diabetes								
Heart Disease								
Hyperlipidemia								
Hypertension								
Kidney Disease								
Osteoporosis								
Seizures								
Stroke								
Thyroid Disease								

Social History Information

Are you adopted? _____Yes _____No Have children? _____Yes _____No

Tobacco Use: ___Current ___Former___Never Type_____ Amt. per day_____ How long?_____

Alcohol Use: ___Current ___Former___Never Type _____ Amt. per day_____ How long?_____

Caffeine Usage Daily_____ Type_____

Do you have an Advance Directive? _____Y _____N