PATIENT INFORMATION

Name: _____ Age: _____ Sex: _____ Date: _____

Preferred Designation: _____ SS#:_____

Birthday: _____ Single: ____ Married: ___ Widowed: ___ Divorced: ____

Address: _____ E-Mail Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: ( )_____ Work Phone #: ( )_____

Occupation: _____ **Cell Phone #: ( )_____**

Responsible party: _____ Employer: _____

Contact in case of an emergency: _____ ( )_____

Referred by: _____

Purpose of Consultation: _____

I. MEDICAL QUESTIONNAIRE (Please indicate with an "X" all that apply)

Have you ever had any Heart problems?		**Gastrointestinal problems?**	
High Blood Pressure	__	Ulcers	__
Low Blood Pressure	__	Gastritis	__
Heart Attack	__	Colitis	__
Heart Murmur	__	Diverticulitis	__
Chest Pain/ tightness	__		
Irregular heart beat	__		
Shortness of Breath	__		

Have you ever had any Lung problems?		**Musculoskeletal/Neurological Problems?**	
Bronchitis/Pneumonia	__	Convulsions	__
Asthma	__	Epilepsy	__
Shortness of breath	__	Headaches	__
Tuberculosis	__	Arthritis	__
		Other	__

Have you ever had any Eye, Ear, Nose or Throat problems?

Dry Eyes	__	Blurred Vision	__	Difficulty breathing	__
Glaucoma	__	Corrective Lenses	__	Nasal Allergies	__
Ear disorders	__	Nosebleeds	__	Sinus Disease	__
Other	__				

Have you ever had any Hematological/Metabolic problems?			
Anemia	__	Bleeding problems	__
Blood transfusions	__	AIDS virus exposure	__
Autoimmune Disease	__	Diabetes	__
Thyroid Disease	__	Hepatitis	__

Have you ever been treated for psychiatric/emotional problems?			
Depression	__	Anxiety	__
Other	__		

Do you have any medical problems that have not been covered?

_____

Do you smoke cigarettes? _____ How much? _____
Do you drink alcoholic beverages? _____ Socially Daily
Do you take any recreational drugs? _____
Patient height _____ Patient Weight _____
Do you take any diet medication? _____

II. MEDICAL HISTORY

Name and city of your personal physician _____
Are you presently under the care of a physician for any medical condition?

_____

_____

A. SURGICAL HISTORY- Please list all previous surgeries (including cosmetic)

Operation Name of Surgeon Date of Surgery

_____

_____

_____

B. HOSPITALIZATION (Others than for surgery)

Illness Physician/Date

_____

_____

_____

III. MEDICATIONS & VITAMINS/DIETS PILLS

Name of Drug Strength/Dosage Condition Treated

_____

_____

_____

IV. ALLLERGIES: (Please list any allergies to any medications, tapes, or antiseptic cleansers)

_____

_____

V. FAMILY HISTORY: (Please indicate if any immediate family member has ever had any of the following?)

Heart Disease	__	Bleeding Disorder	__
Diabetes	__	Autoimmune Disease	__
Anesthetic Complication	__	Others	__

ASSIGNMENT OF BENEFITS:

I hereby authorize the Insurance Company to pay by check made out and mailed directly to _____ the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I agree to pay in current manner, any balance of said Professional Service charges over and above this insurance payment.

Patient Signature Date

Witness Date