



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: _____ Sex Male Female
Social Security Number: _____ - _____ - _____ Date of Birth: ___/___/___
Race: ___ Caucasian ___ African American ___ Latino/Hispanic ___ Asian ___ Native American ___ Other
Ethnicity: ___ Hispanic ___ Non- Hispanic ___ Unknown Preferred Language _____

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 Primary 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: _____ SSN of Policy Holder: _____ - _____ - _____ Date of Birth _____
Address of Policy Holder City: _____ State: _____ Zip: _____
Policy Holder's Phone: _____ Insurance Identification Number _____
Group Identification Number: _____

What is the name of your Secondary 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: _____ SSN of Policy Holder: _____ - _____ - _____ Date of Birth _____
Insurance Identification Number _____ Group Identification Number: _____

Do you have a Tertiary Insurance Provider Yes No

Employment

Status: Retired Full-Time Part-Time Unemployed Other: _____
Name of Employer: _____ Occupation: _____
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 heart beat, 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 any other medical providers involved in your care: _____

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

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

Are you allergic to any medications? _____ If **YES** please medication and reaction 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? (Y/N) Do you have children? (Y/N)

Tobacco Use: ___ Current ___ Former ___ Never Type _____ Units per day _____ Duration _____

Alcohol Use: ___ Current ___ Former ___ Never Type _____ Units per day _____ Duration _____

Caffeine Usage Daily _____ Type _____

Do you have an Advance Directive? (Y/ N)