PATIENT INFORMATION FORM
(All Information Confidential)

PLEASE PRINT

WELCOME TO OUR OFFICE

Date_____

Name_____ Soc Sec # _____M_____F_____
Address_____ City _____ Zip Code_____
Date of Birth _____Age_____Preferred Phone Number_____Marital Status: M S D W
Race_____Spoken Language_____Ethnicity: ❑Hispanic, ❑Non-Hispanic, ❑Refused
Occupation_____ Employer _____ Telephone # _____
Address _____ City _____ Zip Code _____
Email Address _____ Do You Wish To Receive Appt Reminders Via Email? ❑Yes, ❑No
Spouse's Name _____ Spouses Employer/Address_____
_____ Ages of People Living With You _____
Emergency Contact (NOT LIVING WITH YOU): Name_____ Telephone # _____
Referred by: ❑PHYSICIAN ❑INDIVIDUAL ❑HOSPITAL ❑OTHER Name _____
Family Physician _____ Telephone #_____
Address_____ City _____ Zip Code_____

Pharmacy Name _____ Telephone # _____
Address _____ City _____ Zip Code _____

#1 PRIMARY INSURANCE (fill out only if you do not have card)
Name_____
ID#_____
Group # _____

#2 SECONDARY INSURANCE (if you do not have card)
Name _____
ID # _____
Group # _____

HEALTH SYSTEM REVIEW (Please circle no, or yes if currently a problem)

CONSTITUTIONAL	Fevers	Y	N	Weight Loss	Y	N	Anesthesia Problems	Y	N
EYES	Blurred Vision	Y	N	Double Vision	Y	N	Dry Eyes	Y	N
HEART	Chest Pain	Y	N	Irregular Heartbeat	Y	N	Mitral Valve Prolapse	Y	N
LUNGS	Cough	Y	N	Asthma	Y	N	Shortness of Breath	Y	N
DIGESTIVE	Heartburn	Y	N	Nausea	Y	N	Diarrhea	Y	N
SKIN	Rash	Y	N	Itching	Y	N	Dry Skin	Y	N
URINARY	Pain with Urination	Y	N	Frequent Urination	Y	N	Blood In Urine	Y	N
NEUROLOGIC	Headache	Y	N	Slurred Speech	Y	N	Muscle Weakness	Y	N
HEMATOLOGIC	Anemia	Y	N	Abnormal Bleeding	Y	N	Abnormal Bruising	Y	N
PSYCHOLOGICAL	Depression	Y	N	Anxiety	Y	N	Insomnia	Y	N

FAMILY HISTORY (involving your father, mother, brothers or sisters)

ALLERGY	Y	N	HEART DISEASE	Y	N	BLEEDING PROBLEMS	Y	N	THROAT CANCER	Y	N
SINUS	Y	N	DIABETES	Y	N	THYROID CANCER	Y	N	LYMPHOMA	Y	N
HEARING LOSS	Y	N	NEUROLOGIC	Y	N	ESOPHAGEAL CANCER	Y	N	MELANOMA	Y	N

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF INSURANCE BENEFITS
I HAVE COMPLETED THIS FORM FULLY AND COMPLETELY AND CERTIFY THAT THE PATIENT OR DULY AUTHORIZED REPRESENTATIVE COMPLETED THIS FORM

SIGNED_____ DATE_____