Welcome to

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____
Date

Demographics

Patient Name Last First Middle ______________________________ Patient's Social Security Number

______________________________ Date of Birth ____ Male ____ Female ____ Single ___ Married ___Widowed ___Divorced ___Separated

____
Home Address (City, State & ZIP code)

______________ Home Phone # ______________/________ Work Phone # Ext ______________ Alternate / Cell Phone # ______________ E-mail Address

______________ Emergency Contact Name ______________ Emergency Contact Phone# ______________ Relationship to Patient

▶ Referring Physician Name/Practice Name: ______________________________

Insurance Information - *Please present insurance card(s) for copying.*

______________ Primary Insurance ______________ Policy Number ______________ Group Number ______________ Subscriber Name

______________ Subscriber SSN # ______________ Subscriber Date of Birth ______________ Subscribers Employer Name

______________ Secondary Insurance ______________ Policy Number ______________ Group Number ______________ Subscriber Name

______________ Subscriber SSN # ______________ Subscriber Date of Birth ______________ Subscribers Employer Name

Medical Health History

Do you have any medical problems? ☐ Yes ☐ No

Serious Illnesses:

- ☐ Asthma
- ☐ Anemia
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cancer-Organ System? _________
- ☐ Epilepsy
- ☐ Heart Problems
- ☐ Thyroid Problems
- ☐ Other __________________

Previous Surgery:

- ☐ Ear Tubes
- ☐ Tonsillectomy
- ☐ Nose or Sinus Surgery
- ☐ Gallbladder
- ☐ Other ___________________
- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Heart or Bypass Surgery
- ☐ Cancer Surgery

Family members with significant medical problems: ______________________________

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Are you taking any medication? ☐ Yes ☐ No List Meds ______________________________

____

Are you allergic to any medication? ☐ Yes ☐ No List Meds Allergic To ______________________________

____

Do you smoke? ☐ Yes ☐ No If yes, how long & how much?______________________________

Do you drink alcohol? ☐ Yes ☐ No If yes, how long & how much?______________________________

Do you take any recreational drugs? ☐ Yes ☐ No Which Ones? ______________________________