□ 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)