



Date _____	Dr. _____	Account # _____
Referring Physician: _____		PCP: _____

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### Patient Demographic Information

Name of Patient: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

Social Security # \_\_\_\_\_ Email address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Guardian(s) \_\_\_\_\_

To whom may we release information on your behalf? \_\_\_\_\_

\_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

### HEALTH INSURANCE INFORMATION

**Primary Insurance Carrier** \_\_\_\_\_

Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber's DOB: \_\_\_\_-\_\_\_\_-\_\_\_\_ Subscriber's SS # \_\_\_\_-\_\_\_\_-\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

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**Secondary Insurance Carrier** \_\_\_\_\_

Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber's DOB: \_\_\_\_-\_\_\_\_-\_\_\_\_ Subscriber's SS # \_\_\_\_-\_\_\_\_-\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_



Date:	
Account #	Patient:

**FAMILY & SOCIAL HISTORY**

<p><u>Family History</u>          Mother's age _____          Cause of death _____           Father's age _____          Cause of death _____           List any illness that runs in the family:          _____          _____          _____</p>	<p><u>Social History:</u>          Who else lives in your household? _____           Do you smoke? _____          If so, how much? _____          _____           Do you drink? _____          If so, how much? _____          _____           For how long? _____</p>	<p><u>Review of Systems:</u>          Check all that apply.   <input type="checkbox"/> Awaken from sleep with difficulty breathing/coughing  <input type="checkbox"/> Respiratory problems  <input type="checkbox"/> Shortness of breath  <input type="checkbox"/> Chest pain or palpitations  <input type="checkbox"/> Irregular heartbeat  <input type="checkbox"/> Bowel/ bladder problems</p>
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**Medical History**

<p><u>Past Medical History:</u>          Previous Illnesses.          Check all that apply:  <input type="checkbox"/> Asthma            <input type="checkbox"/> Gout  <input type="checkbox"/> Bleeding        <input type="checkbox"/> Jaundice  <input type="checkbox"/> Hepatitis        <input type="checkbox"/> Ulcer/Gerd  <input type="checkbox"/> Lung blood clot <input type="checkbox"/> Hypertension  <input type="checkbox"/> Diabetes        <input type="checkbox"/> Phlebitis  <input type="checkbox"/> COPD            <input type="checkbox"/> Heart disease/attack  <input type="checkbox"/> Emphysema    <input type="checkbox"/> Pneumonia  <input type="checkbox"/> Stroke           <input type="checkbox"/> Thyroid disease  <input type="checkbox"/> Glaucoma       <input type="checkbox"/> Sleep apnea  <input type="checkbox"/> Weight loss    <input type="checkbox"/> Weight gain  <input type="checkbox"/> Kidney or bladder infection  <input type="checkbox"/> Rheumatoid Arthritis  <input type="checkbox"/> Cancer          What kind? _____          _____  <input type="checkbox"/> Other _____          _____          _____</p>	<p><u>Anesthesia History:</u>          Check each type of anesthesia you have had:  <input type="checkbox"/> General      <input type="checkbox"/> Local  <input type="checkbox"/> Regional    <input type="checkbox"/> Spinal          Please list any adverse reactions          _____          _____          _____          _____</p>
	<p><u>Past Surgical History</u>          List all operation and dates of surgery:          _____          _____          _____          _____          _____          _____          _____          _____</p>



Date: _____	
Account # _____	Patient: _____
Referring Physician: _____	PCP: _____

<p>Date of Birth ____/____/____          Age ____    <input type="checkbox"/> Male    <input type="checkbox"/> Female</p> <p><input type="checkbox"/> Single            <input type="checkbox"/> Married  <input type="checkbox"/> Widowed        <input type="checkbox"/> Divorced</p> <p>How were you referred to our office?  <input type="checkbox"/> Physician _____  <input type="checkbox"/> Friend    <input type="checkbox"/> Adjuster    <input type="checkbox"/> Ad  <input type="checkbox"/> Phone Book    <input type="checkbox"/> Internet  <input type="checkbox"/> Attorney _____</p> <p>Have you missed work? _____</p> <p>Date last worked? _____</p>	<p>Describe your injury/condition: _____          _____          _____</p> <p>Is your injury/condition related to:  <input type="checkbox"/> Employment    <input type="checkbox"/> Auto Accident  <input type="checkbox"/> Other (describe) _____</p> <p>When did your injury/condition occur? _____          _____</p> <p>Where did your injury occur? _____          _____</p> <p>Have you seen another physician for this problem?          Who _____</p> <p>Have you have x-rays or an MRI? If so, when/where?          _____          _____</p>
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<p><u>Current Medications &amp; Dosage :</u>          _____          _____          _____          _____</p> <p>Preferred Pharmacy _____          Location: _____</p>	<p><u>Allergies:</u>  <input type="checkbox"/> None            <input type="checkbox"/> Aspirin    <input type="checkbox"/> Codeine  <input type="checkbox"/> Cortisone    <input type="checkbox"/> Demerol    <input type="checkbox"/> Erythromycin  <input type="checkbox"/> Lidocaine    <input type="checkbox"/> Penicillin    <input type="checkbox"/> Sulfa  <input type="checkbox"/> Tetracycline    <input type="checkbox"/> Other _____          _____          _____</p>
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**Physician/Medical Staff Notes**

History:

Physical:

X-Ray:

Diagnosis:

Plan: