PATIENT INFORMATION SHEET:

PLEASE COMPLETE ALL THE QUESTIONS ON THE FORM

PATIENT'S NAME: _____SEX: _ M _ F AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____ SS#: _____-_____-_____

_____ ZIP CODE: _____ EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

ADDRESS: _____

PATIENT/GAURDIAN OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____ BUSINESS PHONE: _____

_____

SPOUSE'S OCCUPATION: _____ EMPLOYER: _____

ADDRESS: _____ BUSINESS PHONE: _____

_____

INSURANCE COMPANY _____ PHONE: _____ ARE YOU PRIMARY INSURED: _ YES _ NO

IF NO: PRIMARY INSURED _____DATE OF BIRTH: _____ SS# _____-_____-_____

HOW WERE YOU REFERRED HERE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: _____

1. Are you allergic or sensitive to any antibiotics or medications? _ Yes _ No

If so, which medications? _ Novacaine _ Aspirin _ Codeine
_ Penicillin _ Cortisone _ Betadine
_ Sulfa _ Erythromycin _ Adhesive Tape
Other _____

2. Are you taking any medications at this time? _Yes _No

If so, please list: _____

_____

3. Do you or have you ever had any of the following?

_ Diabetes	_ Phlebitis	_ Bleeding problems	_ Asthma
_ Arthritis	_ Stroke	_ High Blood Pressure	_ Heart problems
_ Anemia	_ Stomach problems	_ Tuberculosis	_ Liver Trouble
_ Emotional problems	_ Emphysema	_ Gout	_ Thyroid problems
_ Kidney problems	_ Cancer	_ Broken Bones	_ Numbness/Cramps
_ Epilepsy	_ Hepatitis	_ Rheumatic Disease	_ HIV
_ High Cholesterol	_ Ulcers	_ Venereal Disease	_ Blood Disorder

Any other health problems? _____

4. Have you undergone surgery? _ Yes _ No

If yes, what kind and when? _____

5. *For Women:* Are you pregnant? _ Yes _ No

6. Chief complaint that brought you in today? _____

_____

PATIENT SIGNATURE: _____ DATE: _____

PATIENT INFORMATION SHEET PART 2
PLEASE COMPLETE ALL THE QUESTIONS ON THE FORM

PATIENT'S NAME: _____

HEIGHT: ____FT_____INCHES SHOE SIZE: _____

WEIGHT: _____

PHARMACY NAME: _____

ADDRESS/PHONE: _____

FAMILY HISTORY (Parents and Siblings)

___ DIABETES ___ HIGH BLOOD PRESSURE ___ HEART DISEASE ___ ARTHRITIS

___ STROKE ___ HIGH CHOLESTEROL ___ CANCER

SMOKING (please check one)

___ CURRENT EVERYDAY SMOKER ___ FORMER SMOKER

___ CURRENT OCCASIONAL SMOKER ___ NEVER SMOKED

RACE (please check)

___ NOT SPECIFIED ___ AFRICAN AMERICAN

___ AMERICAN INDIAN OR ALASKA NATIVE ___ CAUCASIAN

___ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ___ OTHER

___ ASIAN

ETHNICITY (please check)

___ NOT SPECIFIED

___ HISPANIC OR LATINO

___ NOT HISPANIC OR LATINO

PRIMARY LANGUAGE SPOKEN:_____

ACKNOWLEDGEMENT OF RECEIPT

OF

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

_____ _____

Patient Name (please print) Date

_____

Parent or Authorized Representative (if applicable)

_____

Signature