



**Patient Information**

Last Name

First Name

Middle Initial

Date of Birth

Age

Social Security Number

Sex Male

Female

Address

City

State

ZIP Code

Cell Phone

Home Phone

Work Phone

Email Address

How did you hear about us?

**Responsible Party / Emergency Contact**

Guarantor / Responsible Party

Relationship

Emergency Contact Name

Relationship

Emergency Contact Phone

**Care Coordination**

Preferred Pharmacy

Pharmacy City

Primary Care Physician

Phone

Date of Last Exam



### Primary Insurance

Insurance Company

Subscriber Name

Policy / Member ID

Group Number

Subscriber DOB

Relationship to Subscriber

Subscriber Employer

### Secondary Insurance (if applicable)

Insurance Company

Subscriber Name

Policy / Member ID

Group Number

Subscriber DOB

Relationship to Subscriber

Subscriber Employer

### Financial and Communication Authorizations

I authorize insurance benefits to be paid directly to the physician / clinic.

I understand I am financially responsible for any non-covered balance.

I consent to routine voicemail / text / call reminders at the phone numbers provided.

I acknowledge that insurance cards should be presented at check-in.

*Front desk note: patient should provide insurance card images and photo ID at check-in.*



List current diagnoses, surgeries, medications, and allergies.

**Personal Health History**

1.

2.

3.

4.

5.

6.

7.

8.

**Surgical History**

1.

2.

3.

4.

5.

6.

7.

8.

**Current Medications**

Medication	Strength	Times per Day
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Medication Allergies**

Medication	Reaction
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>



**Family Medical History**

	Mother	Father	Sibling	Notes / Age
Anemia				
Asthma				
Anesthesia Reaction				
Bleeding Disorder				
Cancer				
Diabetes				
Elevated Cholesterol				
Heart Attack				
Heart Disease				
Psychological Disorder				
Other				
Thyroid Disease				

**Lifestyle and Social History**

Do you exercise?	Yes	No	Type	<input type="text"/>	
Are you dieting?	Yes	No	Type of Diet	<input type="text"/>	
Do you drink alcohol?	Yes	No	Drinks / Week	<input type="text"/>	
Do you use tobacco?	Yes	No			
Tobacco Type	Cigarettes	Pipe	Cigars	Chewing	
How many per day	<input type="text"/>	Packs per day	<input type="text"/>	Quit Date	<input type="text"/>



### Patient Consent

This information is true to the best of my knowledge.

I authorize the physician / clinic and my insurance company to release information needed to process claims.

I acknowledge the appointment cancellation / no-show policy and understand missed appointments may incur fees.

I consent to the use and disclosure of health information for treatment, payment, operations, and related HIPAA-permitted purposes.

### Records Release Preferences

Release records requested:

All Records

Operative Reports

Medication Info

Medical Summary

Lab Reports

X-Ray Reports

Progress Notes

Other

Other:

Fax transmission permitted:

Yes

No

### Signature

Patient / Guardian Signature

Date

Printed Name