Demographics

First Name________________________ Last Name________________________

What name does the patient prefer to go by?____________________

Gender_____ Birth Date________________ SSN____________________

Email Address____________________________ Phone Number______________

Address:____

City____________________ State_____ Postal Code__________

How did you hear about us?____________________

RESPONSIBLE PARTY / GUARANTOR INFORMATION

Is the patient also the guarantor?________

Guarantor First Name______________ Guarantor Last Name____________________

Relationship to Patient______________ Phone Number____________________

Address______________________ City______ State_____ Postal Code______

INSURANCE

Name of Insured/Policy Holder______________ Insured's Birth Date__________

Patient's Relationship to Insured: Child/Other/Self/Spouse

Insured Employer Name__________________

Insurance Carrier Name______________ Plan Name________________

ID #________________________ Group #________________

Insurance Company Phone Number____________________________

Insurance's Claims Address__________________________________

Medical History

Please Circle YES or NO

YES NO Allergy - Aspirin

YES NO Allergy - Codeine

YES NO Allergy - Latex

YES NO Allergy - Local Anesthetic

YES NO Allergy - Penicillin

YES NO Allergy - Sulfa

YES NO (High/Low) Blood Pressure

YES NO AIDS/HIV

YES NO Anemia / Bleeding Problems

YES NO Chemotherapy

YES NO Diabetes

YES NO Glaucoma

YES NO Radiation Treatment

YES NO Shortness of Breath

YES NO Sinus Trouble

YES NO Ulcer

YES NO Epilepsy

YES NO Headaches (Frequent)

YES NO Herpes

YES NO Kidney Disease

YES NO Nervous Problems

YES NO Artificial Heart Valves

YES NO Blood Disease

YES NO Congenital Heart Lesions

YES NO Heart Problems

YES NO Pacemaker

YES NO Arthritis / Rheumatism / Gout

YES NO Artificial Joints / Bones

YES NO Asthma

YES NO Cancer

YES NO Emphysema

YES NO Stroke

YES NO Thyroid Problems

YES NO Tuberculosis

YES NO Tumor / growth on head / neck

YES NO Hepatitis

YES NO Fainting / Dizziness

YES NO Liver Disease

YES NO Psychiatric Care

YES NO Do you Smoke?

YES NO Pregnant?

YES NO Nursing?

List any other allergies____

List any other medical issues you have____

List any serious Illnesses / surgeries / hospitalizations_____________________________

List any medications you are taking____

____

Signature_________________________________ Date___________________