Patient Information

OFFICE USE ONLY

PATIENT # ____________ RESPONSIBLE PARTY # ____________ RELATIONSHIP CODE ____________

NAME OF PATIENT: FIRST: ____________________ MIDDLE: ______________ LAST: ______________

ADDRESS: ____

CITY: ______________________ STATE: ______________ ZIP: ______________

TELEPHONE #: HOME (_____) ____________________ DATE OF BIRTH: ______________ AGE ________

SEX: (M-F) ______ MARITAL STATUS: ____________ SOCIAL SECURITY NO.: ______________

EMPLOYER'S NAME: ______________________ WORK TELEPHONE NO.: ______________

REFERRING PHYSICIAN: ______________________ CITY: ______________ STATE: __________

INSURANCE COMPANY NAME	NAME OF POLICY HOLDER	RELATIONSHIP TO PATIENT	GROUP NUMBER	POLICY NUMBER
MEDICARE				
MEDICAID				
BLUE CROSS				
PRIMARY PRIVATE INS.				
SECONDARY PRIVATE INS.				

INSURANCE INFORMATION

If you have insurance, please provide us with a copy of all cards, also if you need precertification for any procedure it is your responsibility to let us know in advance. If you do not have any insurance, you will be held responsible for your bill, payment is expected at the time of your visit unless prior arrangements have been made with the office manager. ALL COPAYS ARE PAYABLE AT THE TIME OF YOUR OFFICE VISIT

INSURANCE HOLDER'S DATE OF BIRTH ______________________ SS# ______________________

NEXT OF KIN NAME: ______________________ RELATIONSHIP: ______________

TELEPHONE #: HOME: ______________________ WORK: ______________________

RESPONSIBLE PARTY'S NAME: ______________________ SS NUMBER: ______________

ADDRESS: ______________________

CITY: ______________________ STATE: ______________ ZIP: ______________

PATIENT RELATIONSHIP TO RESPONSIBLE PARTY: ______________________

DRUG ALLERGIES: ____

I authorize the release of any medical information necessary to process this claim.

Signed: ______________________________ Date: ______________________

I authorize payment of medical benefits to undersigned physician.

____

Signed (Insured or Authorized Person)

Review of Systems

Do you currently, or have you ever, had any problems in the following areas? (If yes, please explain and list medications).

SYSTEM	NO	YES	?	EXPLANATION/MEDICATION
General/Constitutional				
Fever	❑	❑	❑	____
Weight Loss	❑	❑	❑	____
Other	❑	❑	❑	____
Integumentary (Skin)	❑	❑	❑	____
Neurologic				
Headaches	❑	❑	❑	____
Migraines	❑	❑	❑	____
Seizures	❑	❑	❑	____
Respiratory				
Asthma	❑	❑	❑	____
Chronic Bronchitis	❑	❑	❑	____
Emphysema	❑	❑	❑	____
Vascular				
Heart Attack	❑	❑	❑	____
Heart Failure	❑	❑	❑	____
Stroke	❑	❑	❑	____
Heart Pain/Angina	❑	❑	❑	____
High Blood Pressure	❑	❑	❑	____
Vascular Disease	❑	❑	❑	____
Gastrointestinal				
Ulcer	❑	❑	❑	____
Diarrhea	❑	❑	❑	____
Constipation	❑	❑	❑	____
Cirrhosisr	❑	❑	❑	____
Hepatitis	❑	❑	❑	____
Genitourinary (genitals, kidney, bladder)				
Kidney Infection	❑	❑	❑	____
Kidney Stones	❑	❑	❑	____
Bones/Joints/Muscles				
Rheumetoid Arthritis	❑	❑	❑	____
Muscle Pain	❑	❑	❑	____
Joint Pain	❑	❑	❑	____
Lymphatic/Hematologic				
Anemia	❑	❑	❑	____
Bleeding Problems	❑	❑	❑	____
Endocrine				
Thyroid	❑	❑	❑	____
Diabetes	❑	❑	❑	____
Psychiatric	❑	❑	❑	____
Allergic/Immunologic				
Allergies	❑	❑	❑	____
Hay Fever	❑	❑	❑	____
Lupus	❑	❑	❑	____
Sjogrens	❑	❑	❑	____
Other				
Cancer	❑	❑	❑	____

Doctor's Signature______________________________ Review Date ______________

NON-COVERED SERVICES MEDICAL CONSENT FORM

I, ____, understand that some services may not be considered eligible benefits (e.g., services and/or supplies may be determined to not be medically necessary, non-covered or investigational) by my health insurance provider. I understand that my health coverage has certain restrictions and limitations, such as authorization requirements and non-covered services. **Examples of these non-covered items include, but are not limited to , report writing, conferences and/or meetings, drug screens, medical supplies and equipment, etc.** I agree to be financially responsible for any and all related charges if they are not covered by my health insurance provider.

Patient/Guardian Signature:______________________________ Date:_____________

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Medical History Questionnaire

Name: ______________________________ DOB: __________ Date: __________

Medical History

Do you have any allergies to medications, food, etc.? ❑ No ❑ Yes If Yes, explain: ____________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List all major injuries, surgeries and/or hospitalizations you have had: ____________________

List any medical problems/diagnoses you have (i.e. High blood pressure, diabetes, etc.): ____________________

Social History

Do you use tobacco products? ❑ No ❑ Yes If Yes, type/amount/how long: ____________________

Do you drink alcohol? ❑ No ❑ Yes If Yes, type/amount/how long: ____________________

Do you use any other drugs? ❑ No ❑ Yes If Yes, type/amount/how long: ____________________

Check if you have been exposed to or infected with: ❑ Gonorrhea ❑ Syphilis ❑ HIV ❑ Hepatitis