

PLEASE PRINT

First Name	Middle Name	Last Name
SS Number	Date of Birth	Age
Gender	Marital Status	
Address		
City	State	Zip
Student?	Work Status	Email
Home Phone	Work Phone	Cell Phone
Race	Emergency Contact	Emergency Contact Phone
Referred by		

RESPONSIBLE PARTY

Self?	Yes/No	(If no, please provide details below)
Relationship to Patient		
First Name	Middle Name	Last Name
Address		
City	State	Zip
Home Phone	Work Phone	Cell Phone

Do You Have Power of Attorney?	Yes/No (If Yes Please List Info Below)
Name	Phone
Do You Have a Do Not Resuscitate (DNR)?	Yes/No
Do Have a Living Will?	Yes/No
Do you have any special request for the physician regarding end of life care:	

PLEASE PRINT

Primary Insurance		
Carrier Name	Plan Name	Group Number
Relationship of Insured to Patient (If Self, Please fill in only fields with *)		
Insured First Name	Insured Middle Name	Insured Last Name
Insured ID*	Date of Birth	Gender
Address		
City	State	Zip
Home Phone	Insured's Employer Name	
Coverage Start Date*	Coverage End Date (If applicable)	

Secondary Insurance		
Carrier Name	Plan Name	Group Number
Relationship of Insured to Patient (If Self, Please fill in only fields with *)		
Insured First Name	Insured Middle Name	Insured Last Name
Insured ID*	Date of Birth	Gender
Address		
City	State	Zip
Home Phone	Insured's Employer Name	
Coverage Start Date*	Coverage End Date (If applicable)	

Tertiary Insurance		
Carrier Name	Plan Name	Group Number
Relationship of Insured to Patient (If Self, Please fill in only fields with *)		
Insured First Name	Insured Middle Name	Insured Last Name
Insured ID*	Date of Birth	Gender
Address		
City	State	Zip
Home Phone	Insured's Employer Name	
Coverage Start Date*	Coverage End Date (If applicable)	

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Preventive Screening

Exam	Date	Results	Exam	Date	Results
Last Physical Exam			Last PSA		
Last Eye Exam			Last Sigmoid/Colonoscopy		
Last Rectal Exam			Last PPD		
Last Stool Occult			If any Abnormal Results Please Explain Treatment:		
Last Pneumonia Shot					
Last PT/INR					

Past Illness History

Illness Name	Yes	No	Unable to Work?	Result

Past Surgical History

Surgery Name	Date	Place, Physician	Complications

Current Medical History

Please List Any Current Medical History You Would Like To Discuss With The Physician

Are you currently under the care of any specialists: Yes/No (if yes please explain)

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Family & Social History

Do you or your family have any problems with:

	Yes/No	When?		Yes/No	When?
Heart			Auto Immune Disease		
Blood Pressure			Arthritis		
Diabetes			Osteoporosis		
Bleeding Disorder			High Cholesterol		
Cancer			Other:		

Notes:

Tobacco Use (Circle One) **None** Chews Currently Smoking Prev Smoked _____ packs/day

Notes:

Alcohol Use (Circle One) **None** Previously Occasional Moderate to Heavy _____ per/day

Notes:

Substance Abuse History: Yes/No

Notes

Marital Status (Circle One) **Married** Single Separated Divorced Widowed _____ #Children

Diet Preferences	Pets	Travel History	Religious Preference

Allergies

Medication	Reaction	Mild	Moderate	Severe

Food & Environmental Allergies	Reaction	Mild	Moderate	Severe

