

Patient History Sheet (please print)

Date: _____ Patient: _____ SS# _____
Last Name First Name Initial (Preferred-Name)

Mailing Address: _____
City State Zip

Telephone Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Age: _____ Male/Female single married widowed divorced

e-mail: _____ Emergency Contact Name _____ Phone _____

Employer Name: _____ Occupation: _____

Spouse Name: _____ Employer: _____ Date of Birth _____

Who is responsible for this account?: _____ Relationship: _____

Primary Insurance: _____ Name on Policy: _____

Primary Policy No.: _____ Group No.: _____

Secondary Insurance: _____ Name/Policy No.: _____

Referred by: _____ Reason for Consultation _____

If accident, give date and description _____

Medical History

Family Physician _____ Date of Last Physical _____

<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hepatitis, Jaundice or Liver Disease	<input type="checkbox"/> AIDS
<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Cancer	<input type="checkbox"/> Immunodeficiency Disorders
<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Artificial Heart Valves or Joints	<input type="checkbox"/> Chronic Diarrhea	<input type="checkbox"/> Stroke
<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Allergies to Medicine or Drugs	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Back Problems	<input type="checkbox"/> General Allergies	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug /Alcohol Dependency
<input type="checkbox"/> Respiratory Problems	<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Cigarette/Tobacco Use

Do you have any **drug/tape/latex allergies** or have you ever had an adverse reaction to any medication? No

Yes, Explain _____

Have you ever responded adversely to medical or dental treatment? No Yes, Explain _____

Are you taking any medications (including over the counter/non-prescription)? No Yes, What _____

Are you under the care of a physician? No Yes, For what condition _____

Height _____ Weight _____ lbs. Weight loss or gain in the past year _____ lbs. Loss Gain

Do you suspect that you are pregnant? Yes No Are you nursing? Yes No **Do you smoke?** Yes No

Is there anything else we should know about your medical history? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my physician or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I hereby authorize my physician to furnish information concerning my illness and treatment to my insurance company and assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance. I agree to pay the balance within 30 days of receipt of invoice or call the Accounts Manager to arrange payment. All balances over 90 days are subject to a monthly finance charge of 1.5%.

Date _____ Patient's Signature _____