Today's Date: ____/____/____ **Name**:_____ **DOB**:____/____/____

Home Address:_____

Apt#:_____ **State**:_____ **City**:_____ **Zip:**_____

Home #:_____ **Cell #:**_____**Work#:**_____**Ext.**_____

Email:_____ **Last 4 digits of SS#:** _____ **Gender**: M F (Please Circle)

Marital Status: M S Partnered Widowed (Please Circle) **Spouse's Name**:_____**Phone**:_____

Who can we contact in case of any emergency?_____ **Phone**:_____

Primary Care Physician:_____ **Phone**:_____

How were you referred to our office? (Please Circle) Family/Friend/Internet or Physician (If Physician, please provide us with Physician's name, address & phone number.):_____

_____

Please circle Yes/No:

1) Are you currently employed?

Yes/No

2) Are you covered under an employer/union policy?

Yes/No, if yes please specify**:**_____

3) Are you enrolled in **COBRA**?

Yes/No, if yes please specify**:**_____

4) Are you covered under any other health care plan?

Yes/No, if yes please specify**:**_____

5) Have you made any changes to your insurance or Medicare options in the last open enrollment period?

Yes/No, if yes please specify**:**_____

6) Do you have a secondary insurance policy?

Yes/No, if yes please specify**:**_____

7) Is your visit today due to an injury at work?

Yes/No, if yes please specify**:**_____

8) Is your visit today due to injuries sustained in an accident?

Yes/No, if yes please specify**:**_____

Insurance Information:

Primary Insurance: _____

Identification Number: _____

Secondary Insurance: _____

Identification Number: _____

Name of Insured (if different from patient): _____

D.O.B.:___/____/____ Relationship to Patient: Husband/ Wife/ Mother/ Father/Partner (of the Insured)

Employer Information of the Insured Person:

Occupation: _____ Employer Name: _____

Address: _____

I will promptly disclose any necessary information to my insurance carrier to resolve any issues they might have. I understand and agree that regardless of my insurance status (deductibles, co-insurances, copays, pre-existing conditions, etc.), I am ultimately responsible for the balance of my account for any professional services rendered and any collection fees. I have read the information on this sheet and completed all of the above answers. I certify that all of the information is true and correct to the best of my knowledge. I will notify you of any change in my status or in my insurance information ***(I understand that if I fail to notify you within 15days of services rendered of a change of insurance, claims could be denied and I will be responsible for the bill)****.*

Signature (Authorized Person):_____ **Date**:____/____/_____

MEDICAL HISTORY

Please List all Medical Problems:

1. **5.**
2. **6.**
3. **7.**
4. **8.**

What is the reason for today's visit?_____

	YES	NO
High Blood Pressure		
Diabetes		
Stomach or Intestinal Ulcers		
Cancer		
Exposure to Tuberculosis (TB)		
Heart Murmurs/Mitral Prolapse		
Pacemaker/Defibrillator		
Blood Clots/Phlebitis		
Heart Failure		
Coronary Heart Disease/MI		
Stroke/CVA/TIA		
Irregular Heartbeat/Arrhythmia		
Artificial Joints (if so which joint(s)		
Artificial Heart Valves (If so which valves)		
Rheumatic Heart Disease		
Seizures		
Hepatitis (If so which type)		
Liver problems		
Kidney Problems		
H.I.V./A.I.D.S.		
Bleeding Disorder		
Skin Cancer Which Type? Where? When?		
Herpes/Cold Sores		
Raised Scars/Keloids		

Do you have any family history of ?

	YES	NO	In Whom?
Psoriasis			
Eczema			
Asthma			
Environmental Allergies			
Skin Cancer (What Type?)			

Are you exposed to any chemicals at work? (If so, to what?) _____

Please list any surgeries you have had and their dates:

1. **3.**

2. **4.**

Do you have any history of skin diseases? (If so,to what?) _____

Do you have any allergies to any medications, if so to what? (Please include topical medications and bandages)_____

Have you ever had a bad reaction to Novocaine/Xylocaine/Lidocaine? (If so to which one/what was the reaction?)_____

Are you Pregnant? _____ **Last Pregnancy? _____**

Are you breastfeeding?_____ **Are you planning pregnancy?_____**

Please list all medications you are taking including Aspirin, vitamins, herbs, and any over the counter medications (O.T.C.):

1. **4.**
2. **5.**
3. **6.**

Have you ever smoked? _____ How Long?_____ How often?_____

PATIENT HIPAA ACKNOWLEDGEMENT

I, acknowledge the receipt and fully understand the HIPAA PRIVACY PRACTICE NOTICE:

Print Name **Date**

Signature

If patient is a minor, name of personal representative and relationship to patient

Accounting of Disclosures: **(For Office Use Only)**

Date of Request:	Name of Person/Organization where PHI was sent:	Records Sent:	Preparer of Records:	Date Sent: