PATIENT INFORMATION

Name _____ Soc. Sec# _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❒ M ❒ F Age _____ Birthday _____ ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Work Phone _____

INSURANCE INFORMATION

Subscriber Name _____ Subscriber ID# _____

Company Name _____ Date of Birth _____ Group # _____

Address for Claims _____ Phone # _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

Date of Last Visit _____ Have you had any serious illnesses or operations ❒ Y ❒ N

If yes, describe _____

Are you currently under physician care? ❒ Y ❒ N If yes, describe _____

Have you ever had a blood transfusion? ❒ Y ❒ N If yes, give approximate dates _____

Women: Are you pregnant? ❒ Y ❒ N Nursing? ❒ Y ❒ N Taking birth control pills? ❒ Y ❒ N

Check (✓) yes or no whether you have had any of the following:

❒ Y ❒ N AIDS/ HIV Positive
❒ Y ❒ N Anaphylaxis
❒ Y ❒ N Anemia
❒ Y ❒ N Arthritis, Rheumatism
❒ Y ❒ N Artificial Heart Valves
❒ Y ❒ N Artificial Joints
❒ Y ❒ N Asthma
❒ Y ❒ N Atopic (allergy prone)
❒ Y ❒ N Back Problems
❒ Y ❒ N Blood Disease
❒ Y ❒ N Cancer
❒ Y ❒ N Chemical Dependency
❒ Y ❒ N Chemotherapy
❒ Y ❒ N Circulatory Problems
❒ Y ❒ N Cortisone Treatments
❒ Y ❒ N Cough, Persistent
❒ Y ❒ N Cough up blood
❒ Y ❒ N Diabetes
❒ Y ❒ N Epilepsy
❒ Y ❒ N Fainting
❒ Y ❒ N Food Allergies
❒ Y ❒ N Glaucoma
❒ Y ❒ N Headaches
❒ Y ❒ N Heart Murmur
❒ Y ❒ N Heart Problems
Describe _____
❒ Y ❒ N Hemophilia/ Abnormal Bleeding
❒ Y ❒ N Hepatitis
❒ Y ❒ N Herpes
❒ Y ❒ N High Blood Pressure
❒ Y ❒ N Jaw Pain
❒ Y ❒ N Kidney disease or Malfunction
❒ Y ❒ N Liver Disease
❒ Y ❒ N Material Allergies (latex, wool, metal, chemicals)
❒ Y ❒ N Mitral Valve Prolapse
❒ Y ❒ N Nervous Problems
❒ Y ❒ N Pacemaker/Heart Surgery
❒ Y ❒ N Psychiatric Care
❒ Y ❒ N Radiation Treatment
❒ Y ❒ N Rapid Weight Gain or Loss
❒ Y ❒ N Respiratory Disease
❒ Y ❒ N Rheumatic/ Scarlet Fever
❒ Y ❒ N Shingles
❒ Y ❒ N Shortness of Breath
❒ Y ❒ N Skin Rash
❒ Y ❒ N Spina Bifide
❒ Y ❒ N Stroke
❒ Y ❒ N Surgical Implant
❒ Y ❒ N Swelling of Feet or Ankles
❒ Y ❒ N Thyroid Disease or Malfunction
❒ Y ❒ N Tobacco Habit
❒ Y ❒ N Tonsillitis
❒ Y ❒ N Tuberculosis
❒ Y ❒ N Ulcer/Colitis
❒ Y ❒ N Venereal Disease

Is patient currently taking any medications? If yes, list all: _____

Does patient have drug allergies? If yes, list all: _____

Signature _____ **Date** _____

Payment is due in full at time of treatment unless prior arrangements have been made.