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PATIENT INFORMATION

Last Name: _____ **First:** _____ **M.I:** _____
Address: _____
City: _____ **State:** _____ **Zip:** _____ **Marital Status: S M D W** **Sex: M F**
Home Phone #: _____ **Cell Phone #:** _____ **Work #:** _____
Race/Ethnicity: _____ **Date of Birth:** _____ **SS #:** _____
Preferred language: _____
Email Address: _____ May send information here? Yes No

Employer Name & Address: _____
Occupation: _____ Employment Status: Full time / Part time / Student

Referred to this office by:

_____

Primary Care Physician:

_____

In case of emergency contact: _____ Relationship: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Work Phone: ( ) _____ ext. _____
Email Address: _____ May send information here? Yes No

Pharmacy Name, Address & Phone #:

_____

_____

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Responsible Party Information

Name of Spouse: _____ Date of Birth: _____ Age: _____
Occupation: _____ SSN: _____
Employer: _____ Employer's Phone: _____

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Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home Phone ( ) _____ Cell Phone: ( ) _____
Male/Female Date of Birth: _____ SSN: _____
Email Address: _____ May send information here? Yes No
Occupation _____
Employer: _____ Work Phone: _____

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May we leave a message at your home? Yes No May we contact you at work? Yes No

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CURRENT MEDICATIONS:

Prescription Medications

1. _____ dosage _____ directions _____
2. _____ dosage _____ directions _____
3. _____ dosage _____ directions _____
4. _____ dosage _____ directions _____
5. _____ dosage _____ directions _____
6. _____ dosage _____ directions _____
7. _____ dosage _____ directions _____
8. _____ dosage _____ directions _____
9. _____ dosage _____ directions _____

Over-the-Counter Medications: 1. _____ **2.** _____ **3.** _____

Allergies to Medications: _____

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SOCIAL HISTORY:

Do you smoke? Yes / No **Date began to smoke?** _____ **How much?** _____

If you quit, quit date: _____/_____/_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information. I authorize the release of any medical information necessary to process an insurance claim.

Responsible Party Signature: _____ Date: _____