TO ALL PATIENTS: Many insurance companies now require patients to have authorization from their primary care physician to receive care from a specialist physician. It is your responsibility to make sure this authorization is obtained before you are seen. Copayments must be paid on the day of service.

PATIENT INFORMATION: Today's date_____

Last Name_____ First Name_____ MI_____ Sex (circle) M F

Date of Birth_____ Soc. Sec. #_____ Cell Phone (____)_____ Home Phone (____)_____

Street Address_____ City_____ State_____ Zip_____

Employer Name_____ Occupation_____ Work Phone (____)_____

Spouse's Name_____ Other family members seen_____

Referred by_____ Email address_____

RESPONSIBLE PARTY OF MINOR CHILDREN:(if different from above)

Father's Last Name_____ First Name_____ MI _____ Phone (____)_____

Street Address_____ City_____ State_____ Zip_____

Mother's Last Name_____ First Name_____ MI_____ Phone (____)_____

Street Address_____ City_____ State_____ Zip_____

INSURANCE INFORMATION: (Present your insurance card(s) to the receptionist)

Primary Insurance_____ Copay Amount_____

Policy Holder's Information:

Name_____ Date of Birth_____

Soc. Sec. # or ID # _____ Group #_____

Employer_____ Phone (____)_____

Secondary Insurance_____ Copay Amount_____

Policy holder's information:

Name_____ Date of Birth_____

Soc. Sec. # or ID # _____ Group #_____

Employer_____ Phone (____)_____

NEAREST FRIEND OR RELATIVE *NOT* LIVING WITH YOU:

Name_____ Relationship to patient_____ Phone (____)_____

Street Address_____ City_____ State_____ Zip_____

(OVER)

HEALTH HISTORY

Have you ever had :

Yes	No		Yes	No		Yes	No	
_____	_____	Bleeding tendency (Including family history)	_____	_____	Stroke	_____	_____	Epilepsy or convulsions
_____	_____	Lung Disease, TB	_____	_____	Known occupational exposure to loud noises or chemical compounds (e.g. Benzene)	_____	_____	Diabetes
_____	_____	Asthma or wheezing				_____	_____	Hepatitis
_____	_____	Emphysema	_____	_____	Metal implants, clips rods, etc.	_____	_____	Other illness:
_____	_____	Heart disease						_____
_____	_____	Angina or chest pain	_____	_____	Migraines			_____
_____	_____	Irregular heart beats	_____	_____	Cancer (including family history)			** Mental illness, drug addiction, HIV or AIDS, please discuss with the physician.
_____	_____	High blood pressure	_____	_____	Pacemaker			

Explanation of the above "yes" answers: _____

_____

List any past surgeries you have had: _____

List any medication you are currently taking: _____

_____

List any medications you are allergic to: _____

Do you drink alcoholic beverages? Y N How much? _____

Do you or have you ever smoked? Y N How much? _____

How many years? _____ Have you quit? Y N If yes, when? _____ Do chew tobacco? Y N

Who is your primary care physician? _____

Are you currently under the care of any other physician(s)? _____

Women - Is there any possibility that you are pregnant? Y N How many months? _____

I authorize insurance payment of medical benefits to Theodore M. Mazer, M.D. If payment for services is denied due to lack of prior authorization, I will be responsible for payment of services rendered.

I understand that penalties for past due accounts ($25) or returned checks ($15 plus bank fees) may apply.

Failure to attend a scheduled appointment, or cancel at least 24 hours in advance (except for emergencies), may result in a no-show fee of $25 for which I agree to be personally responsible.

Patient or authorized person's signature _____