NEW PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____
Address: _____ Apt/Space: _____
City: _____ State: _____ Zip: _____

Primary Doctor: _____ City: _____
Contact Information: _____

How would you like us to contact you for appointment reminders?
Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Ext:
Cell: (____) _____-_____ Email Address: _____

Social Security: _____-_____-_____ **Date of Birth:** _____/_____/_____ Sex: [ ] Male [ ] Female
Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Ethnic Background: [ ] Asian [ ] African American [ ] White [ ] Native American
[ ] Hispanic-Country: _____ [ ] Other: _____

Preferred Language: _____
Employer: _____ Occupation: _____
How did you hear about us: _____

Insurance Information
Primary Insurance: _____
ID Number: _____ Group #_____ Plan:_____
Name on account:_____
Relationship to patient: _____

Secondary Insurance: _____
ID Number: _____ Group #_____ Plan:_____
Name on account:_____
Relationship to patient: _____

Billing Address (If different from primary residence): [ ] N/A
Address: _____ Apt/Space: _____
City: _____ State: _____ Zip: _____

The filing of insurance claims is a courtesy we extend to our patients. We are happy to assist you in billing most insurance companies, however; we must emphasize that your insurance is a contract between you and your insurance company. We are not party to that contract. While many of the services provided in this office are covered by most insurance companies, there are cases when the service or supply will not be fully covered. By signing this form, you agree to allow this office to bill your insurance company and provide them with any medical information related to you in order to expedite the payment process. You also agree, that that if the services and/or supplies are not covered by your insurance, you are personally responsible for the outstanding balance due. If the patient is a minor, the person bringing the minor into the office for treatment will be help responsible for the total amount of the balance due.

_____ _____
Patient Signature/ Legal Guardian Date

CONTINUE ON BACK -------->

HEALTH HISTORY

Are you diabetic? [ ] Yes [ ] No
If yes, what medications do you take? _____

Do you take Aspirin daily? [ ] Yes [ ] No

Do you currently have a Pace Maker in place? [ ] Yes [ ] No

Do you have a Pacemaker in place? [ ] Yes [ ] No

Do you take blood thinners such as Coumadin? [ ] Yes [ ] No

Do you have any allergies? [ ] Yes [ ] No
If yes, please list: _____

Do you smoke? [ ] Yes [ ] No
If yes, how many packs per day? _____ How long?_____
If no, but you smoked in the past, how long did you smoke and when did you quit? _____

Do you have a family history of any of the following conditions, and who in your family had them?
[ ]Diabetes : _____
[ ]Heart Attack : _____
[ ]Cancer : _____
[ ]High Blood Pressure : _____
[ ]Gout : _____
[ ]Arthritis : _____
[ ]Stroke : _____

Are you taking any medications? If so, please list below or attach a copy:
_____
_____
_____
_____
_____
_____

Preferred Pharmacy:

Name of Pharmacy and Location (street and nearest cross street)