# PATIENT INFORMATION - DO NOT LEAVE ANY PORTION BLANK

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| PLEASE PRINT the following information. | | | | |
| Name: | | | | |
| Employer: | Occupation: | | | |
| Employer Address: | | | | |
| If patient needs an interpreter,  provide interpreter name & phone: | | Name:  Phone: | | |
| If patient is a minor, name of guardian:  Guardian Phone number: | | | Social Security Number:  Relationship: | |
| Person financially responsible for treatment, if not self: | | | | |
| Address of person financially responsible: | | | | Phone: |
| **Do you have an attorney representing you for the injury being treated: YES NO**  Attorney Name:  Attorney Address:  Attorney Phone Number:  Attorney Fax Number:  Attorney Email: | | | | |
| **Did this injury occur at work? YES NO**  What is your job? Employer: Supervisor name: Phone:  Workers’ Compensation Carrier: Policy number: Phone: Claim: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Did this injury involve an automobile accident? YES NO**  **Patient** Auto Insurance Carrier: Policy: Phone: Claim:  **Other Driver** Auto Ins. Carrier: Policy: Phone: Claim:  **Any Other Party** Auto Ins. Carrier: Policy: Phone: Claim: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Were your injuries the result of a crime? YES NO**  If so, please provide a brief description:  PHARMACY  Preferred Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PATIENT RESPONSIBILITIES  As a patient, you are responsible for:   * Following the care, service, or treatment plan developed for you. * Telling your provider if you believe you cannot follow through with your treatment plan and understanding the possible results if you decide not to follow the recommended treatment plan. * Asking questions when you do not understand what you have been told about your care. * Attending follow up appointments and physical therapy appointments as prescribed. Failure to do so may result in sub-optimal medical outcomes. * By signing below, I acknowledge and accept these responsibilities and consent to treatment.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_  Patient/Guardian (signature) Date  Relationship to Patient, if not signed by Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| HEALTH INSURANCE INFORMATION  *(If patient does not have health insurance, please skip to next set of boxes)* | | |
| PRIMARY INSURANCE: | MEMBER ID: | GROUP #: |
| SUBSCRIBER NAME: | SUBSCRIBER DATE OF BIRTH: | SUBSCRIBER ADDRESS: |
| IS YOUR INSURANCE PROVIDED BY AN EMPLOYER  YES NO | NAME OF EMPLOYER/ADDRESS/PHONE NUMBER: | |
| SECONDARY INSURANCE: | MEMBER ID: | GROUP #: |
| SUBSCRIBER NAME: | SUBSCRIBER DATE OF BIRTH: | SUBSCRIBER ADDRESS: |
| IS YOUR INSURANCE PROVIDED BY AN EMPLOYER  YES NO | NAME OF EMPLOYER/ADDRESS/PHONE NUMBER: | |
| I have truthfully entered the above information to the best of my knowledge. I also understand that I am responsible for ensuring that I obtain proper authorizations and complete the necessary paperwork to process my claim as required by my health insurance carrier and this medical office. I also understand that I am responsible for my portion of deductibles, copays, coinsurance and cost share.  Patient and/or Guardian Signature:  Date: | | |

### MEDICAL HISTORY

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| Describe the injury/illness and how long this injury/illness has concerned you: | | |
| Have you had any previous treatment for this? If YES, how and when was this treated?  How did you hear about our office? | | |
| Circle/List any and all MEDICAL PROBLEMS: |  |  |
| Heart Disease/CAD High Blood Pressure | Blood disorder | Migraines |
| Atrial Fibrillation High Cholesterol  PE/ DVT Diabetes  Peripheral Vasc. Disease Asthma/ COPD | Thyroid Disorder  GERD/PUD  Kidney Failure | Back Pain  Depression  Anxiety |
|  |  |  |
| Other: |  |  |
| List any and all HOSPITALIZATIONS and reason(s) for hospitalization: | | |
| Have you ever been on contact isolation in the hospital (MRSA, VRE, C.Diff, etc.)? YES NO | | |
| List any and all SURGERIES and dates: | | |
| Have you had a problem with anesthesia in the past? | YES NO |  |
| Please list **ALL** medications taken regularly **INCLUDING** aspirin, birth control pills, herbs, vitamins, etc. | | |
| Are you allergic to or have you ever had a reaction to any medication or drug; local anesthetic, or general anesthetic? If so, please list medication and type of reaction: | | |
| Do you have any allergies to surgical implants? | YES NO |  |
| Alcohol use: How much do you drink? How often? | | |
| Tobacco Use: Never smoke or vape / Currently smoke or vape / Formerly smoke or vape / Smokeless Tobacco  How many packs per day do you smoke? How many years? | | |
| Recreational Drug Use? If YES, please list substance: | | |
| Family history, circle all that apply: Bleeding Disorders / Abnormal Clotting / Autoimmune Disorder / Cancer / Diabetes / Heart Disease / High Blood Pressure / Malignant Hypothermia / Anesthesia Problems | | |
| **The provided medical history information on this page and the preceding page is truthful and accurate to the best of my knowledge. Failure to inform the practice of prior surgeries or medical history may (1) lead to adverse medical consequences, (2) may change the cost of surgical procedures and, (3) will void any prior financial quotes for procedures.**  **Patient or Guardian Signature: Date:** | | |

**PLEASE ONLY MARK THOSE CONDITIONS THAT APPLY TO YOU.**

* Normal
* Rash or itching
* Change in skin color

**Skin – Check all that apply**

* Change in hair or nails
* Varicose veins
* Fatigue
* Headaches
* Good general health lately
* Recent weight gain
* Fever

**Constitutional – Check all that apply**

* Normal ☐ Nose bleeds
* Hearing loss ☐ Mouth sores
* Ringing in the ears ☐ Bleeding gums
* Earaches or drainage ☐ Bad breath
* Sinus problems ☐ Sore throat

**ENT – Check all that apply**

* Normal ☐ Muscle pain or cramps
* Joint pain ☐ Back pain
* Joint stiffness or swelling ☐ Cold extremities
* Weakness of muscles or joints ☐ Difficulty walking

**Musculoskeletal – Check all that apply**

* Normal
* Frequent urination
* Burning or painful urination
* Blood in urine
* Change or force of strain when urinating

**Genitourinary – Check all that apply**

* Incontinence or dribbling
* Kidney stones
* Blurred/Double Vision
* Glaucoma
* Wear glasses/Contacts
* Good General Vision
* Eye Disease or Injury

**Eyes – Check all that apply**

* Normal
* Heart trouble
* Chest pains
* Sudden heart beat chang
* Swelling of feet, ankles, or hands

**Cardiovascular – Check all that apply**

* Normal
* Loss of Appetite
* Nausea or vomiting
* Change in bowel movements
* Painful bowel movements

**Gastrointestinal – Check all that apply**

* Normal
* Frequent coughing
* Spitting up blood
* Shortness of breath
* Asthma or wheezing

**Respiratory – Check all that apply**

* Sleep Apnea
* Snoring
* Sleepiness
* Frequent waking at night
* Stomach pain
* Blood in stool
* Constipation
* Diarrhea
* Normal
* Heart trouble
* Chest pains
* Sudden heart beat changes
* Swelling of feet, ankles, or hands

**Cardiovascular – Check all that apply**

* Normal
* Heart trouble
* Chest pains
* Sudden heart beat changes
* Swelling of feet, ankles, or hands

**Cardiovascular – Check all that apply**

* Normal
* Glandular or hormone problem
* Thyroid disease
* Excessive thirst or urination

**Endocrine – Check all that apply**

* Heat or cold intolerance
* Dry Skin
* Normal
* Heart trouble
* Chest pains

**Cardiovascular – Check all that apply**

* Sudden heart beat changes
* Swelling of feet, ankles, or hands
* Normal
* Frequent or recurring headaches
* Light headed or dizzy
* Convulsions or seizures
* Numbness or tingling sensations

**Neurological – Check all that apply**

* Tremors
* Paralysis
* Stroke
* Normal
* Slow to heal after cuts
* Easily bruise or bleed
* Anemia

**Hematologic – Check all that apply**

* Phlebitis
* Past transfusion
* Enlarged glands
* Normal
* Memory loss or confusion
* Nervousness

**Psychiatric – Check all that apply**

* Depression
* Anxiety
* Sleep problems

**Allergic/Immunologic – Check all that apply**

* Normal
* Environmental allergy
* Food Allergy