Patient Information

Last Name _____ **First Name** _____ **M.I.** _____

Street Address _____ Apt. # _____

City _____ State _____ Zip Code_____Marital Status: Single____Married____Divorced_____Widow(er)_____

Employer _____ Business Phone _____ Home Phone _____

Date of Birth _____ Social Security _____ Sex _____

Cell Phone _____ Responsible party for payment: Self_____Spouse_____Parent_____Other_____

Emergency Contact _____ _____
Name and Relationship Phone Number

Address of Emergency Contact_____

Primary Insurance Holder (if different from patient)

Last Name _____ **First Name** _____ **M.I.** _____

Relationship to patient: Spouse _____ Parent _____ Other _____

Street Address _____ Apt. # _____

City _____ State _____ Zip Code_____Marital Status: Single____Married____Divorced_____Widow(er)_____

Home Phone _____ Business Phone _____ Employer _____

Date of Birth _____ Social Security _____ Sex _____

If there is a secondary insurance, please complete the following:

Last Name _____ **First Name** _____ **M.I.** _____

Relationship to patient: Spouse _____ Parent _____ Other _____

Street Address _____ Apt. # _____

City _____ State _____ Zip Code_____Marital Status: Single____Married____Divorced_____Widow(er)_____

Home Phone _____ Business Phone _____ Employer _____

Date of Birth _____ Social Security _____ Sex _____

I accept financial responsibility for any balance due (co-insurance, deductible and insured responsibility) after my insurance has paid. I further authorize the release of pertinent medical information to my insurance company in order to facilitate the payment of claims. I accept full responsibility for following up with recommended tests and/or procedures and calling the doctor to obtain the results.

_____Patient or Guardian Signature Date _____

(rev 09/06)

Patient Name:_____ Today's date: _____/_____/_____

Please list the name(s) of your doctor(s)

Name: _____ Name: _____

Address:_____ Address:_____

_____ _____

Phone: _____ Phone: _____

Fax #: _____ Fax #: _____

Have you ever had an audiogram (hearing test)? _____YES _____NO

List all medications you take: **Including over the counter medications, vitamins, or herbal supplements:**

_____ _____

_____ _____

_____ _____

List all allergies to medications: _____

Do you smoke? _____ If yes, how much? _____ Do you drink: _____ If yes, how much? _____

What is your height _____ Weight _____

Do you or any of your family members have the following illnesses?

	Myself	Family members (indicate relationship to patient)
Bleeding tendency	_____	_____
Diabetes	_____	_____
High blood pressure	_____	_____
Heart disease	_____	_____
Asthma / Emphysema	_____	_____
Cancer (if yes, what type)	_____	_____
Hepatitis / Liver disease	_____	_____
Thyroid disease	_____	_____
Kidney disease	_____	_____
Seizures or stroke	_____	_____
HIV or immune deficiency	_____	_____
Other	_____	_____

Please list all previous surgeries and hospitalizations (with dates if known)

_____

_____

_____

Review of Systems: Are you currently experiencing any of the following symptoms?

			****Do not write in this box, doctor's use only****	
			Problem list w/dates	Surgeries with dates
Fatigue	Yes	No		
Vision changes	Yes	No		
Chest pain / palpitations	Yes	No		
Shortness of breath	Yes	No		
Digestive problems	Yes	No		
Urinary Difficulties	Yes	No		
Muscle / Joint pains	Yes	No		
Changes in skin	Yes	No		
Blood changes	Yes	No		
Bruising / Bleeding	Yes	No	_____	_____ (rev 06/09)