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PATIENT INTAKE

Please Print Clearly

TODAY'S DATE:_____

First Name:_____
Middle Name:_____
Last Name:_____
Date of Birth_____
Social Security #:_____
Address:_____
_____
City:_____
State:_____ Zip Code:_____
City:_____
Home Phone:_____
Mobile Phone:_____
Work Phone:_____
May We Leave a Detailed Message:_____
E-Mail:_____

Reason for Visit:_____
_____
Primary Care Provider:_____
_____
Local Pharmacy:_____
Street, City:_____
Drug Allergies:_____
_____
_____
_____
Gender: _____ Male _____ Female
Height: _____ Weight:_____
Marital Status:_____
Race:_____ Ethnicity:_____
Primary Language:_____
Emergency Contact Name and Phone:
_____

INSURANCE INFORMATION

Primary Insurance :_____
_____
Policy Number:_____
Subscriber Name:_____
Subscriber D/O/B:_____
Relationship to Patient:
_____ Self _____Spouse _____Parent

Secondary Insurance:_____
_____
Policy Number:_____
Subscriber Name:_____
Subscriber D/O/B:_____
Relationship to Patient:
_____ Self _____Spouse _____Parent

Guarantor (If different from Patient):_____

MEDICAL HISTORY

Please check all that apply to you:

_____ Allergy	_____ Asthma	_____ Excema
_____ Diabetes	_____ Thyroid Disorder	_____ Hearing Loss
_____ Ringing in Ear (Tinnitus)	_____ High Blood Pressure	_____ Sinus Infections
_____ Ear Infections	_____ Acid Reflux (GERD)	_____ Pneumonia
_____ Stroke	_____ Migraine	

List any other medical history not listed :_____
_____

History of MRSA (Methicillin Resistant Staphylococcus Aureus)? _____ Yes _____ No

FAMILY HISTORY

Please check all that apply to your family members:

_____ Allergy	_____ Asthma	_____ Excema
_____ Diabetes	_____ Thyroid Disorder	_____ Hearing Loss
_____ Ringing in Ear (Tinnitus)	_____ High Blood Pressure	_____ Sinus Infections
_____ Ear Infections	_____ Acid Reflux (GERD)	_____ Pneumonia
_____ Stroke	_____ Migraine	

List any other medical history not listed :_____

_____

SURGICAL HISTORY

Surgery/Hospitalization	Year	Complications?
_____	_____	_____
_____	_____	_____
_____	_____	_____

DAILY MEDICATION LIST

Medication Name	Dose	Reason for Medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

_____ Employed _____ Work in Home _____ Retired _____Student

Name of Employer:_____ Occupation:_____

Do you live alone? _____ How often do you exercise?_____

History of Substance abuse? _____ Yes _____ No

If yes, what type of substance?_____

Alcohol Consumption? _____ Yes _____ No

If yes, how often? _____ Daily _____ 2-3 times per week _____ Socially

Tobacco Use? _____ Yes _____ Former Smoker _____ Never Smoked

Current Smoker:

What do you smoke?_____ (cigarette, pipe, cigar)

How much do you smoke?_____ How long have you smoked?_____

Former Smoker: When did you quit?_____

How much did you smoke?_____ How long did you smoke?_____

_____ Date:_____

Signature of Patient / Parent / Guardian