PATIENT INFORMATION SHEET

Last First Middle

Patient"s Name _____

Sex: M___ F___ Marital Status: Single_____ Married_____ Widowed_____ Divorced_____

Address _____

City _____ State_____ Zip Code _____

Home Telephone Number _____ Cell Number _____

Email Address _____

Date of Birth: _____ Social Security Number _____

Are you Employed?_____ Full Time_____ Part Time_____

Are you Retired?_____ Date of Retirement_____

Place of Employment_____ Telephone Number_____

IT IS VERY IMPORTANT THAT YOU PROVIDE US WITH YOUR COMPLETE, ACCURATE, AND CURRENT INSURANCE COVERAGE. We are a participating provider with many insurance companies. As a part of our contracts we are required to file your claims to these companies. If you have insurance through your employer that insurance is primary and must be filed first. Insurance through your spouse's employer is secondary and will be filed after we hear from the primary insurance. **WE MUST HAVE A COPY OF ALL INSURANCE CARDS.**

Do you have insurance coverage through your employer? _____

Insurance Plan _____

Policy Number _____ ID Number _____

Are you covered on spouses insurance plan ___ _____

Spouse's Name _____

Date of Birth _____ Social Security Number _____

Is Spouse Employed? _____ Full Time _____ Part Time _____ Retired? _____ Date of Retirement _____

Place of Employment _____ Telephone Number _____

Address of Employer _____

Insurance Plan _____

Policy Number _____ ID Number _____

Are you on Medicare? _____ Medicaid? _____

Do you have any other insurance coverage? _____ Please List: _____

_____

_____

Person to contact in case of an emergency: Name_____

Address_____

Phone _____

Referred by _____

OVER

MINOR PATIENT INFORMATION SHEET

Patient Name _____ Sex: M: ___ F:___
LAST FIRST MIDDLE

Address _____

City _____ State _____ Zip _____

Student? _____ Full-Time _____ Part-Time _____

School _____

Home Phone _____

Date of Birth:_____ SS# _____

PARENT OR GUARDIAN INFORMATION

Father's Name _____

Address _____

City, State, Zip _____

Date of Birth_____ SS# _____

Home Phone _____

Place of Employment _____

Work Phone _____

Mother's Name _____

Address _____

City, State, Zip _____

Date of Birth _____ SS# _____

Home Phone _____

Place of Employment _____

Work Phone _____

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Father's Ins. Co. _____

Is this PRIMARY COVERAGE? _____

Mother's Ins. Co. _____

Is this PRIMARY COVERAGE? _____

Is this patient covered under any **other** insurance?

Insured Name _____

SS#_____ DOB _____

Employer _____

Phone # _____

Relationship to patient _____

Insurance Co. _____

(OVER)

PATIENT HISTORY SHEET

Name: Soc. Sec. #: Date:

Date of Birth: Sex: Age:

Occupation:

Referred by Dr.: Family Physician, Dr.:

State briefly the problem(s) for which you were referred here:

Are you allergic to any medicine?

List medicines you take - (also bring them with you):

PAST HISTORY:

Have you ever had skin cancer or melanoma?

Has any immediate family member had skin cancer or melanoma?

Have you been treated for skin problems in the past?

Unusual childhood illness?

Have you ever had any of the following?

Weight change over the past year	Rheumatic Fever
Goiter or Thyroid Trouble	Pneumonia
Ever had X-Ray treatment to head or neck	Malaria
Kidney or Bladder Infections	Cancer
Kidney Stones	Epilepsy
Hepatitis or Yellow Jaundice	Stroke
Stomach or Duodenal Ulcer, Colon Trouble	Diabetes (sugar)
High Blood Pressure	Asthma
Heart Trouble	Pleurisy
Heart Murmur	Last eye exam - Glaucoma check
Tuberculosis (T.B.)	Last Pap. Smear
Last EKG (Electrocardiogram)	Menstrual Problems
Last Chest X-Ray	

- Please Continue Over -

List operations, serious injuries, fractures, hospitalizations, and dates of each:

PERSONAL HISTORY:

Married?	Age of spouse?	Health?
Children?	Ages?	Health?
Hobbies?		
Do you smoke?	What?	How much?
Do you drink alcoholic beverages?	What?	How much?
Work - How many hours a week?	What is your job?	
Are you on disability?	Are you on medicare?	
Are you on medicaid?	Are you on workman's compensation?	

FAMILY HISTORY:

	Age	Living	Dead	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any members of your immediate family (blood relative) had:

- Diabetes
- Tuberculosis
- Heart Trouble
- Cancer
- High Blood Pressure
- Stroke
- Goiter
- Rheumatoid Arthritis
- Blood Disease