

Patient History
Please Complete as Fully as possible

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____ - _____ Work Phone: () _____ - _____

Cell Phone: () _____ - _____ Email address: _____

Birthdate: ____/____/____ Social Security: ____ - ____ - ____

Financial Responsible Party (if different from above):

Name: _____

Address: _____

Phone: () _____ - _____

Family Physician & Address: _____

Are you presently taking any medications? Yes / No

If yes, please list all: _____

Name & Address of the Pharmacy you use: _____

Do you have any allergies to any medications? Yes / No

If yes, please check all that apply and any reaction you experience:

Aspirin _____ Codeine _____ Penicillin _____

Iodine _____ Demerol _____ Novocaine _____

Sulfa _____ Tylenol _____ Other _____

I have or have had the following (please check all that apply):

____ Diabetes _____ Asthma

____ Stroke _____ Gout

____ Liver Disease _____ Arthritis

____ Kidney Disease _____ Glaucoma

____ Stomach Ulcers _____ Bleeding Tendencies

____ Joint Replacement _____ Anemia

____ High Blood Pressure _____ Poor Circulation

____ Irregular Heart Beat/Arrhythmia _____ Thyroid ____ (hyper) ____ (hypo)

____ Other _____

Nature of Problem: _____

Referred By: _____

Marital Status: M_____ How many years? _____
W_____ D_____ S_____

Number of children _____

Do you drink alcohol? No____ Yes____ How much? _____

Do you presently smoke? No____ Yes____ How much? _____

Do you have a past history of smoking? No_____ Yes_____

If yes, please describe: _____

Do you exercise regularly? No____ Yes____

If yes, please describe _____

Are you presently employed? No_____ Yes_____

If yes, please describe your type of work _____

Please list below any previous surgeries you have had and their dates, if available:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name (please print)

Date

Parent or Authorized Representative (if applicable)

Signature