

PATIENT INFORMATION

Patient's Name:			
Home Address:	City:	State:	Zip:
Alternate Address:	City:	State:	Zip:
Home Telephone:	Cell Phone:	Work Phone:	
Date of Birth:	Age: SSN	N	
Email Address (optional):			_
Height:Current Weight:l	Jsual WeightHave you had a	a recent weight gain or lo	ss: Yes or No
INSURANCE INFORMATION *	*Please attach card to clipboard f	or copying	
Primary Ins:	Policy #	Group#	
Insured Name:	Insured Date	of Birth:	
Insured Employer:	Employer Phone	number:	
Secondary Ins. (if applicable):	Policy #	#Gro	oup#
Insured Name:	Insured Date o	of Birth:	
Insured Employer:	Employer Phone n	number:	
GUARANTOR INFORMATION:			
Patient			
Guarantor Name:	Relations	ship:	
Address:			
Phone: SSN	: Email Addres	SS:	
DRUG ALLERGIES Please list any כנ	ırrent or past reactions.	I DO NOT have any	drug allergies.
Allergy to (drug, latex, shell	fish, iodine) Reac	tions (itching, coughing, h	nives, etc)
IEDICATIONS, Please list all medicat	tions you take with or without a pro	ecrintian (use additiona	I naner if needed)
Medication Name		Dosage/# per day	
		_	
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MEDICAL HISTORY Please check i	f you have ever been diagnosed with the follow	wing:
□ Angina □ Anxiety/Panic Attacks □ Anemia □ Arthritis □ Asthma □ Atrial Fibrillation □ Blood Clots, where: □ Bronchitis □ Cancer. Type: □ Chronic Fatigue Syndrome □ Colitis □ Coronary Artery Disease □ Depression □ Diabetes	 Emphysema Fibromyalgia GERD (Reflux) Gallbladder Disease Gout Heart Attack, Hemophilia/Bleeding Disorder Hepatitis A / B / C High Blood Pressure High Cholesterol Irregular Heartbeat Kidney Disease Liver Disease 	□ Migraines □ MRSA □ Osteoarthritis □ Osteomyelitis (bone infection □ Osteopenia □ Osteoporosis □ Other Heart Disease □ Rheumatic Fever □ Pneumonia □ Rheumatoid Arthritis □ Thyroid Disease □ Tuberculosis □ Stomach Ulcers
Are there any other medical problems w	ve should know about?	
SOCIAL HISTORY		
Do you live alone? Yes or No I	f no, with whom do you live?	
Do you use tobacco? Yes or No	f yes, what product and how long?	
Do you drink alcohol products? Yes	or No If yes, what and how often?	
Do you use recreational drugs? Yes	or No	
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SURGERIES or PROCEDURES (us		I HAVE NOT HAD any surgeries.
St	urgery (describe type)	Year