PATIENT INFORMATION SHEET:

PLEASE COMPLETE ALL THE QUESTIONS ON THE FORM

PATIENT'S NAME: ______________________ SEX: _ M _ F AGE: ________ DATE OF BIRTH: __________

ADDRESS: ______________________ SS#: ________-________-________

______________________ ZIP CODE: __________ EMAIL: ______________________

HOME PHONE: ______________________ CELL PHONE: ______________________

PRIMARY CARE PHYSICIAN: ______________________ PHONE: ______________________

ADDRESS: ______________________

PATIENT/GAURDIAN OCCUPATION: ______________________ EMPLOYER: ______________________

ADDRESS: ______________________ BUSINESS PHONE: ______________________

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SPOUSE'S OCCUPATION: ______________________ EMPLOYER: ______________________

ADDRESS: ______________________ BUSINESS PHONE: ______________________

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INSURANCE COMPANY ______________________ PHONE: ______________ ARE YOU PRIMARY INSURED: _ YES _ NO

IF NO: PRIMARY INSURED ______________________ DATE OF BIRTH: ________ SS# ________-________-________

HOW WERE YOU REFERRED HERE: ______________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP: ______________________

ADDRESS: ______________________ PHONE: ______________________

1. Are you allergic or sensitive to any antibiotics or medications? _ Yes _ No

   If so, which medications?
   _ Novacaine _ Aspirin _ Codeine
   _ Penicillin _ Cortisone _ Betadine
   _ Sulfa _ Erythromycin _ Adhesive Tape
   Other ______________________

2. Are you taking any medications at this time? _Yes _No

   If so, please list: ______________________

   ____

3. Do you or have you ever had any of the following?

_ Diabetes	_ Phlebitis	_ Bleeding problems	_ Asthma
_ Arthritis	_ Stroke	_ High Blood Pressure	_ Heart problems
_ Anemia	_ Stomach problems	_ Tuberculosis	_ Liver Trouble
_ Emotional problems	_ Emphysema	_ Gout	_ Thyroid problems
_ Kidney problems	_ Cancer	_ Broken Bones	_ Numbness/Cramps
_ Epilepsy	_ Hepatitis	_ Rheumatic Disease	_ HIV
_ High Cholesterol	_ Ulcers	_ Venereal Disease	_ Blood Disorder

   Any other health problems? ______________________

4. Have you undergone surgery? _ Yes _ No

   If yes, what kind and when? ______________________

5. *For Women:* Are you pregnant? _ Yes _ No

6. Chief complaint that brought you in today? ______________________

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PATIENT SIGNATURE: ______________________ DATE: ______________