(Please Print and Fill in Completely) Referred by: _____

PATIENT INFORMATION ☐ MR. ☐ MRS. ☐ MS. ☐ MD ☐ OTHER ☐ **MALE** ☐ **FEMALE** _____**ETHNICITY**

_____**RACE** _____**NATIONALITY** _____**PRIMARY LANGUAGE** _____**DOMINANT HAND**

_____ AGE_____

First Middle Maiden Last

☐ Partner ☐ Widow ☐ Divorced ☐ Separated ☐ Married ☐ Single BIRTHDATE _____

HOME ADDRESS_____
Street City Zip

BILLING ADDRESS _____ E-MAIL _____
Street City Zip

HOME PHONE _____ CELL PHONE _____

SOCIAL SECURITY NO. _____ DRIVER LICENSE #_____ STATE _____

EMPLOYER_____ OCCUPATION_____

BUSINESS ADDRESS _____ PHONE _____

IN CASE OF EMERGENCY: CONTACT PERSON: _____ RELATION: _____ PHONE: _____

ADDRESS _____

INSURANCE INFORMATION

NAME OF POLICY HOLDER: _____ RELATION: _____MEDICARE #_____

PRIMARY INSURANCE COMPANY NAME _____ POLICY OR CERTIFICATE #_____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME_____ POLICY OR CERTIFICATE #_____ GROUP #_____

DO YOU HAVE A PRESCRIPTION CARD? ☐ YES ☐ NO IF **YES** PLEASE PROVIDE YOUR:

PHARMACY NAME_____ PHARMACY ID# _____ PHARMACY TEL. NO._____

IN ORDER TO PREVENT MISUNDERSTANDING ABOUT MEDICAL OR SURGICAL INSURANCE WE WISH OUR PATIENTS TO KNOW THAT:

1. **ALL PATIENTS SERVICES FURNISHED ARE CHARGED DIRECTLY TO THE PATIENT AT THE TIME SERVICES ARE RENDERED.**
2. **PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS.**

WE WILL PREPARE NECESSARY REPORTS FOR SURGICAL PROCEDURES TO HELP COLLECT YOUR BENEFITS FROM INSURANCE COMPANIES. IF THE INSURANCE COMPANIES MAIL US THE CHECK WE WILL CREDIT THESE TO YOUR ACCOUNT. EACH FEE IS INDIVIDUAL WITH THE PATIENT. WE ENCOURAGE YOU TO DISCUSS FEES WITH US PRIOR TO RECEIVING MEDICAL SERVICES.

MEDICAL HISTORY

1. LIST SIGNIFICANT CURRENT ILLNESSES: _____

_____

2. FAMILY PHYSICIANS NAME _____ TELEPHONE _____

ADDRESS_____ CITY _____

3. ARE YOU TAKING ANY MEDICATION? _____ IF SO, WHAT?_____

4. PLEASE CHECK ILLNESSES YOU HAVE HAD: ☐ ALLERGIES ☐ ASTHMA ☐ TUBERCULOSIS ☐ ANEMIA ☐ RHEUMATIC FEVER

☐ LIVER TROUBLE ☐ HEART TROUBLE ☐ HIGH BLOOD PRESSURE ☐ DIABETES ☐ KIDNEY TROUBLE ☐ OTHER _____

_____

PREVIOUS DERMATOLOGIC OR ALLERGIC HISTORY_____

FAMILY DERMATOLOGIC OR ALLERGY HISTORY_____

ARE YOU SUBJECT TO: ☐ NERVOUS DISORDERS ☐ DIZZY SPELLS ☐ FAINTING ☐ PROLONGED BLEEDING

☐ UNUSUAL REACTONS TO ANY ANESTHETIC OR DRUG ARE YOU PREGNANT? _____ IF SO, HOW MANY MONTHS? _____

HAVE YOU EVER HAD AN OPERATION? _____ IF SO, WHAT?_____

_____

ANY OTHER INFORMATION YOU FEEL WE SHOULD KNOW ABOUT YOUR HEALTH:_____

SIGNATURE _____