



Patient Information

LAST NAME _____
FIRST NAME _____ MI _____
HOME PHONE _____ WORK _____ CELL _____
E-MAIL ADDRESS: _____
HOME ADDRESS: _____
CITY _____ ST _____ ZIP _____
DATE OF BIRTH _____ SSN _____

PRIMARY CARE PRIMARY PHYSICIAN _____
PRIMARY CARE PRIMARY PHYSICIAN'S PHONE _____

HOW DO YOU PREFER TO BE CONTACTED?
HOME _____ WORK _____ CELL _____ E-MAIL _____

DO WE HAVE YOUR PERMISSION TO LEAVE MESSAGES AT:
HOME _____ CELL _____
WITH FAMILY MEMBER (SPECIFY) _____

MAY WE CALL YOU AT WORK? Y__ N__
MAY WE LEAVE MESSAGE (S) AT WORK? Y__ N__

SIGNATURE

DATE

Insurance Information

PRIMARY NAME _____ POLICY NUMBER _____
GROUP _____ POLICY HOLDER'S NAME _____
POLICY HOLDER'S DATE OF BIRTH AND SSN _____

SECONDARY NAME _____ POLICY NUMBER _____
GROUP _____ POLICY HOLDER'S NAME _____
POLICY HOLDER'S DATE OF BIRTH AND SSN _____



MEDICAL HISTORY

Cancer type: _____ Any chemo- or radiation therapy? _____

History of skin cancer, if yes, what type? Basal cell Squamous cell Melanoma

Please check to indicate any history of:

Asthma	Emphysema	Allergies
Heart Attack	High Blood Pressure	Heart Murmur
Pacemaker	Stroke	Irregular Heartbeat
Reflux (GERD)	Phlebitis	Diabetes
Glaucoma	Thyroid Disease	Anemia
Aneurysm	Hepatitis A, B, C	HIV / AIDS
Seizures	Cataracts	STD
Arthritis	Blood Clots	Kidney Stones
High Cholesterol	Depression / Anxiety	Other pertinent

Surgeries:

Appendectomy	Hysterectomy	Tonsillectomy
Adenoidectomy	Tubal Ligation	Cataracts
Gall Bladder	Ovary Removal	Vasectomy
Hernia Repair	Knee Repair (Meniscus)	Rotator Cuff Repair
Thyroid Removal	Goiter	Wisdom Teeth
Deviated Septum	Heart Catherization	Angioplasty
ByPass Surgery	Spleen Removed	Colostomy
Hemorrhoid Removal	Lumpectomy (breast)	Carpal Tunnel

Any artificial joints: _____

Any other surgeries? _____

Are you interested in any cosmetic procedures? _____