Referred by_________________

Last Name ________________________ First Name ____________________________ MI___________

Address ____ Apt___________

City __________________________ _State ____________________ Zip Code____________________

Date of Birth ___/____/_____ Age ________ Sex________ Social Security____/____/_______

Home#_____________________ Office#______________________ Cell#_________________________

Email Address____

Employer's Name__________________________________ Occupation __________________________

Address________________________________ City______________ State________ Zip Code_________

Emergency Contact___________________________________ Phone #___________________________

Relationship_______________________________

Insurance Information

Subscribers name ________________________

Relationship to Subscriber ( ) Self ( ) Spouse ( ) Child ( ) other

Subscriber Date of birth____ /___/_____ Social Security#_______________________

Insurance Company____________________________ ID#____________________ Group#___________

I authorize payment of medical benefits to the physician. I further authorize the release the release of any information necessary to process these medical claims. I understand that I am financially responsible for all deductibles, co-payments, referral, non-covered services, and vaccines that may apply as directed by my insurance company directly. If my insurance plan does NOT cover these costs, I agree to pay for the services.

___________________________ ___________________________

Signature of Patient Date

It is the policy of this office to bill for any missed appointments unless given at least 24 hours notice. I understand that unless I give such notice, I will be charged the rate of the routine visit.

___________________________ _____________________________

Signature of Patient Date

Medical History

Name________________________________ **Date** ____________

Please list any problems to want to discuss with the doctor?

____

How long have you had this problem? ________________________

What is the nature of your pain? ( ) Sharp ( ) Dull ( ) Aching Stabbing ( ) Other

Rate your pain 0 1 2 3 4 5 6 7 8 9 10 (severe)

Is there history of injury? ( ) yes ( ) No * Date of Injury?_________

Is this a work related injury? ( ) yes ( ) No

Is your condition getting better or worse? ____________________

What seems to make the condition/ pain worse? _______________

____

What seems to make the condition/pain better? _______________

____

Have you seen any other physician for your condition? __________

____

Please list any treatments you have had for this condition_______

____

Has this condition affected your ability to work, exercise or perform

If so, how? ____

Notes

(Doctor's use only)

Past Medical History

(Please check one of the following)

( ) High blood pressure	( ) Sickle cell	( ) Leukemia /Lymphoma	( ) Cohn's disease
( ) Stroke/ TLA	( ) Thaslassemia	( ) Colitis	( ) Ulcerative colitis
( ) Angina / Heart attack	( ) Diabetes	( ) Multiple sclerosis	( ) Lyme disease
( ) Heart rhythm disorder	( ) Eye disease	( ) Cerebral palsy	( ) HIV/ AIDS
( ) Heart valve problem	( ) Kidney disease/Dialysis	( ) Polio	( ) Syphilis
( ) Heart failure	( ) Neuropathy	( ) Seizure/Epilepsy	( ) Liver disease/ Hepatitis B or C
( ) Asthma/ COPD	( ) Thyroid disorder	( ) Muscular dystrophy	( ) Tuberculosis
( ) Blood clot in vein	( ) High cholesterol	( ) Panic/ anxiety disorder	( ) Rheumatic fever
( )Pulmonary embolus	( ) Osteoarthritis	( ) Bipolar illness/depression	( ) Sleep apnea
( )Chronic bronchitis	( ) Lupus /SLE	( ) Psychiatric illness	( ) Back trouble / Sciatica
( ) Sarcoidosis	( ) Rheumatoid arthritis	( ) Dementia/ Alzheimer's	( ) Skin Disorder
( ) Reynaud's	( )Psoriasis	( ) Stomach ulcers	( )Use of steroids in the past 6 months
( ) Anemia	( ) Gout	( ) Reflux/ GERD	( ) Other medical problems:
( ) Blood transfusion	( )Cancer	( ) Spinal cord injury	
( ) Bleeding tendency	Type:	Level:	

Please list all previous surgeries and Hospitalizations:

( ) Foot	( )Hip	( )other vascular bypass
( ) Ankle	( ) Angioplasty (balloon / stent)	( )other:
( ) Knee	( ) Coronary (Heart) bypass	
( ) Back	( ) Hernia	

Have you ever had difficulty with anesthesia? ( ) yes ( ) No   Bleeding after surgery? ( ) Yes ( ) No

List or attach a complete list of all your current Medications:

Pharmacy Information:
Pharmacy name: ____________________________ Pharmacy phone#_______________________
Pharmacy address____

Primary Doctor Information
Primary doctor name:_______________________________ Phone #________________________
Address:____

Last Tetanus immunization: Date _______________ ( ) Unknown ( ) < 5 years ( ) < 10 Years

Allergies:( ) None ( ) Penicillin ( ) Aspirin ( ) Contrast ( ) Latex ( ) Iodine ( ) Shellfish ( ) Tape
( ) Gluten Intolerance ( ) food allergies ( ) Metal Other ____

Social History:
( ) Married ( ) Single ( ) Widowed ( ) Divorced ( ) Partnered
Have you ever used illicit drugs? ( ) Yes ( ) No
Abused prescription medications, drugs or alcohol? ( ) Yes ( ) No
Do you ever drink alcohol?( ) Yes ( ) No How often?__________________ How much?_____________
Have you ever used tobacco? ( ) Yes ( ) No Amount per day:______ Age began ______ Quite at age____
What is your Occupation?___________________ Are you retired?( ) Yes ( )No Disabled? ( ) yes ( ) No
Currently using hormones or oral contraceptives? ( ) Yes ( ) No ( ) N/A
Women: Breastfeeding? ( ) Yes ( ) No could you be pregnant now? ( ) Yes ( ) No

Are there any disease/ illnesses that seem to run in your family? _________________________________
____

To the best of my Knowledge, I have answered the questions on this form as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes to my medial status.

____
Print Name of Patient **Signature of Patient / Parent/ Guardian** **Date**

____
Signature of Doctor **Date**

PATIENT CONSENT FOR USE OF ELECTRONIC MAIL

Patient Date of Birth ____

PATIENT e-mail____ _______

PATIENT ACKNOWLEGDMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risk associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions herein, as well as any other instructions that may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Signature: ____

Date:____