Patient Information Form

(Please Print)

Name:		
Street Address:		
City, State: Zip:		
DOB:	Sex:	
Social Security #:		Ethnicity:
Home Phone: May we identify our clinic in phone messages? ❑ Yes ❑ No		Employer:
Cell Phone: May we identify our clinic in phone messages? ❑ Yes ❑ No		Work Phone: May we identify our clinic in phone messages? ❑ Yes ❑ No
Pharmacy #:		Email Address:

If Patient is a minor:

Parent/Guardian's Name:	His/Her SS#:	His/Her DOB:
Address:	Telephone:	

Insurance Information

Primary Insurance Company: Co-pay Amount:		
Policy Holder Name:	SS#:	
Policy/ID#:	Group #:	
Secondary Insurance Company:		
Policy Holder Name:	SS#:	
Policy/ID#:	Group #:	

Emergency Contact

Contact Name:	Relationship:	Phone:
How did you hear about us?		

MEDICAL PROFILE

Please list **all** current medications you are taking (or have taken in the past two weeks):

Prescribed by:	Medication:	Dosage:	Taken how long?

Allergies: _____ _____

Current Medical Conditions (please check):

□□Allergies
□□Asthma
□□Arthritis
□□Back Trouble
□□Cancer
□□Heart Problem
□□Chronic Pain
□□Diabetes
□□Frequent Constipation
□□Frequent Headaches
□□Hay Fever
□□Hearing Problem
□□Irritable Bowel Syndrome
□□Stomach Problems
□□Skin Problems
□□Vision Problems
□□High Blood Pressure
□□Other:_____

Primary Care Doctor: Phone #:
Date of last physical exam:__

May we collaborate with your Primary MD? □□Yes □□No

Are you currently under a physician's care? □□Yes□□□No If yes, physician:
_____

Date Last Seen: _ Problem:_____
Significant past medical problems, if not indicated above:

Hospitalizations/ surgeries:
_____
Rate your current physical health: □□Excellent □□Good □□Fair □□Poor