PATIENT INFORMATION RECORD

PATIENT (LAST NAME) (FIRST NAME) (MIDDLE INITIAL) | DATE OF BIRTH

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED | ☐ MALE ☐ FEMALE

HOME ADDRESS

CITY | STATE | ZIP CODE | HOME PHONE

PATIENT EMPLOYED BY | OCCUPATION

BUSINESS ADDRESS | BUSINESS PHONE EXT.

SOCIAL SECURITY NUMBER | DRIVER'S LICENSE NUMBER

NAME OF SPOUSE | DATE OF BIRTH

SPOUSE EMPLOYED BY | OCCUPATION

BUSINESS ADDRESS | BUSINESS PHONE EXT.

SOCIAL SECURITY NUMBER | DRIVER'S LICENSE NUMBER

NEAREST RELATIVE NOT LIVING WITH YOU | HOME PHONE

HOME ADDRESS | CITY | STATE | ZIP CODE

PATIENT REFERRED BY

CURRENT MEDICAL DOCTOR | TELEPHONE NUMBER | DATE OF LAST PHYSICAL

DENTIST | DATE OF LAST CHECK-UP

IF PATIENT IS A MINOR, NAME OF PERSON RESPONSIBLE

DO YOU HAVE MEDICAL INSURANCE? ☐ YES ☐ NO | NAME OF INSURED

INSURANCE COMPANY AND ADDRESS | GROUP NUMBER

MEDICARE NUMBER | MEDI-CAL NUMBER

IS THIS A WORK RELATED INJURY? ☐ YES ☐ NO | DATE OF ACCIDENT

WILL AN ATTORNEY BE HANDLING YOUR MEDICAL FEES? ☐ YES ☐ NO | DATE OF ACCIDENT

NAME OF ATTORNEY | ADDRESS

If you have health insurance, it is an agreement between you and your insurance company. Your doctor's bill is an agreement between you and your doctor. We will bill your insurance for you, however, you will still be responsible for any balance which is not paid by your insurance company.

SIGNATURE | DATE

MEDICAL HISTORY

		CIRCLE ONE	
1.	Are you having pain or discomfort at this time?	YES	NO
2.	Have you had any major operations?	YES	NO
3.	Have you been under the care of a medical doctor during the past two years?	YES	NO
4.	Have you taken any medicine or drugs during the past two years or presently taking medication?	YES	NO
	Please list medications: ______		
5.	Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?	YES	NO
6.	Have you ever had any excessive bleeding requiring special treatment?	YES	NO

7. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS or Immune Deficiency
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Veneral Disease (Syphilis, Gonorrhea)
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Genital Herpes
Artificial Joint	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
	Hip Replacements	Bruise Easily

8.	When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?	YES	NO
9.	Do your ankles swell during the day?	YES	NO
10.	Do you use more than 2 pillows to sleep?	YES	NO
11.	Have you lost or gained more than 10 pounds in the past year? How much	______	
12.	Do you ever wake up from sleep short of breath?	YES	NO
13.	Are you on a special diet?	YES	NO
14.	Has your medical doctor ever said you have a cancer or tumor?	YES	NO
15.	Do you have any disease, condition, or problem not listed?	YES	NO
16.	WOMEN: Are you pregnant now?	YES	NO
	Are you taking oral contraceptives or on hormone therapy?	YES	NO
	Do you anticipate becoming pregnant?	YES	NO
17.	Have you or your family had a problem with general anesthesia?	YES	NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

______ ______

Date *Signature of Patient, Parent or Guardian*