NEW PATIENT INFORMATION SHEET

Date: _____

Patient's Name: _____

Last First Middle Initial

Address: _____

Number & Street City State Zip

Phone Numbers: Daytime:_____ Evening:_____

Date of Birth:_____ Marital Status:_____

Employer: _____

Business Address: _____

Social Security Number: _____

Type of Insurance: _____

Policy Number: _____

Please Answer the Following Questions

1. Are you presently taking any medication?
   If yes, please list_____
   _____
   _____
   _____
2. Are you allergic to any medication?
   If yes, please list_____
   _____
3. Are you currently under the care of a doctor for any reason?
   If yes, please explain_____
   _____
   _____
4. Have you been hospitalized in the past five years for more than two days?
   If yes, please explain_____
   _____
   _____
   _____

5. Please circle any of the following you have (had):

Anemia	Cardiac Pacemaker	Heart Trouble	Rheumatic Fever
Arthritis	Convulsions	Hepatitis	Sinus Trouble
Asthma	Diabetes	High Blood Pressure	Stroke
Any Blood Disease	Epilepsy	Jaundice	Tuberculosis
Bleeding Problems	Glaucoma	Kidney Problems	Ulcers
Cancer	Heart Murmur	Psychiatric Treatment	X-Ray Treatment

6. Any other serious illness? _____

_____

_____

_____

Comments/Notes

Patient's Signature:

_____

Signature of Responsible Party:

_____