MEDICAL HISTORY

1. Are you now under a Physician's care? _____ If so, please give reason _____

_____

2. Your physician's name: _____
3. What medications are you now taking? (Include birth control pills, vitamin supplements, and over the counter medicines)

_____

_____

_____

4. Please check medical problems you have or have had:

( ) AIDS or positive HIV Test	( ) Hives	( ) Sinus problems
( ) Allergies	( ) Skin cancer	( ) Asthma
( ) Tuberculosis	( ) Diabetes	( ) Ulcers
( ) Bleeding disorder	( ) Hay Fever	( ) Cancer
( ) Hepatitis or liver disorder	( ) Keloids or thick scars	( ) High blood pressure
( ) Kidney trouble	( ) Heart trouble	( ) Rheumatic Fever

5. Is there any **family history** of:

( ) Allergies	( ) Asthma	( ) Eczema
( ) Hair loss	( ) Melanoma or abnormal moles	( ) Hives
( ) Psoriasis	( ) Skin cancer	( ) Hay Fever

6. Are you subject to any nervous disorders, dizzy spells, or fainting? _____
7. Have you ever had unusual reactions to any local anesthetic or drug? _____
8. Have you been required to take antibiotics before dental or surgical procedure? _____
9. Are you pregnant? _____ How many months? _____
10. Have you ever had an operations? _____ If so, what? _____

MEDICARE SIGNATURE FORM

I request payment of authorized Medicare benefits made either to me or on my behalf to Simone A. McKitty, M.D. for any services rendered to me by that physician/supplier. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services.

Signature of Patient _____

OUT OF NETWORK

I will be using the Out of Network (including COVERED CALIFORNIA) portion of my medical insurance. I understand that the deductible and co-payments will be different than my preferred provider option (PPO) benefit plan. I acknowledge that Dr. Simone A. McKitty is not a preferred provider for the PPO portion of my insurance.

Signature of Patient _____

OPTING OUT OF MEDICARE and HMO INSURANCE

I will be opting out of Medicare and or my HMO insurance for my visits. I do not want Medicare or my HMO billed for this visit. I will personally be responsible for my visits.

Signature of Patient _____