WELCOME

P/	ATIEN?	r informatio	ON	9. _	PRIM	ARY IN	SURANCI	<u> </u>
		Date						
Patient				Who is re	esponsible	for this accour	nt?	
				Relations	ship to Patie	ent		
				Insuranc	e Co			
	City	State	Zip	ID#				
Sex: M	F Age	e Birthdate			SI	ECONDARY I	NSURANCE	
Single	Married	Widowed Separated	Divorced	Subscrib	er Name _			
Patient SS#_				1 1				
Occupation_				11				
Employer				1 1				
Employer Add	dress							
Employer Pho	one			New pati	ents or thos	se patients wi	th a change in the	ir insurance
3pouse/Partr	ner's Name_			informati	on must pro	ovide a valid ir	nsurance card or t	emporary
3irthdate		SS#					ld you be unable to pay in full at time	
Occupation_							rance carrier at yo	
Spouse/Partner's Employer			convenie	nce for rein	nbursement. I	understand by sig	ning below	
Whom may we thank for referring you?							the office of any o	hanges to
Name of your	r primary phy	ysician, address & phone		I my insur	ance or cor	ntact information	OH.	
				Responsib	e Party SIgnatur	е	Date	
3 c	ONTAC	T INFO		Responsib	, ,	9	Date	
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MUSCLE/JOINT/BONE Pain, weakness, numbness in: Arms Hips Back Legs Feet Neck Hands Shoulders GENITO-URINARY Blood in urine	☐ Rectal bleeding☐ Stomach pain☐ Vomiting☐ Vomiting blood	☐ Persistent cough☐ Ringing in ears☐ Sinus problems	☐ Nipple discharge☐ Painful intercourse
Pain, weakness, numbness in: Arms Hips Back Legs Feet Neck Hands Shoulders GENITO-URINARY Blood in urine	☐ Stomach pain ☐ Vomiting ☐ Vomiting blood	☐ Ringing in ears ☐ Sinus problems	Painful intercourse
Arms Hips Back Legs Feet Neck Hands Shoulders GENITO-URINARY Blood in urine	☐ Vomiting ☐ Vomiting blood	☐ Sinus problems	
Back Legs Feet Neck Hands Shoulders GENITO-URINARY Blood in urine	☐ Vomiting blood		
Feet Neck Hands Shoulders GENITO-URINARY Blood in urine	_		Vaginal discharge
Hands Shoulders GENITO-URINARY Blood in urine	CARDIOVASCIII AR		☐ Other
GENITO-URINARY Blood in urine		SKIN	Date of last
Blood in urine	☐ Chest pain	☐ Bruise easily	menstrual period
Blood in urine	☐ High/Low blood pressure	☐ Hives	Date of last
	☐ Irregular/Rapid heart beat	☐ Itching/Rash	Pap Smear
Frequent urination	☐ Poor circulation	☐ Change in moles	Have you had
Lack of bladder control	☐ Swelling of ankles	☐ Scars	a mammogram?
Painful urination	☐ Varicose veins	Sore that won't heal	Are you pregnant?
		□ Sole that world flear	Number of children
heck (✓) conditions you have or	have had in the past.		
AIDS	☐ Chicken Pox	☐ HIV Positive	☐ Polio
Appendicitis	☐ Diabetes	☐ Kidney Disease	☐ Prostate Problem
Arthritis	☐ Emphysema	☐ Liver Disease	☐ Rheumatic Fever
Asthma	☐ Epilepsy	☐ Measles	☐ Scarlet Fever
Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Stroke
Breast Lump	☐ Heart Disease	☐ Multiple Sclerosis	☐ Thyroid Problems
Cancer	☐ Hepatitis	☐ Mumps	☐ Tuberculosis
Cataracts	Herpes	☐ Pacemaker	Ulcers
Chemical Dependency	☐ High Cholesterol	☐ Pneumonia	☐ Venereal Disease
	rations		
ate of last physical examination			
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MEDICATION	NS/ALLERGIES	7 HEALTH	HARITS
O MEDICATION	NO/IIDDDRUIDO		IIIIDI I O
ist medications you are currently	/ taking	HEALTH HABITS Check (which substances you use	,
		describe how much you use	e. you to the following:
harmacy Name	Phone	☐ Caffeine	Stress
паппасу паппе	FIIONE	1 1	
st allergies to medications or sul	bstances	Drugs	
3		Tobacco	_ Hazardous Substand
		Other	Other
SIGNATURES	8		
<u> </u>			
	on is correct to the best of my kr sions that I may have made in the	nowledge. I will not hold my doctor e completion of this form.	or any members of his/her st
		D	ate
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