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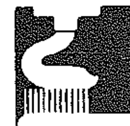

WELCOME

Thank You For Selecting Us.

To help us meet all your healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

PATIENT INFORMATION (Confidential)

Name ______________________ Date ______________
Address ______________ City __________ State ______ Zip __________
Home Phone # ______________ E-Mail: ______________
Driver's License # ______________ Soc. Sec. # ______________ Birthdate ______________
Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Employer's Name ______________________ Work Phone ______________
Work Address ______________ City __________ State ______ Zip __________
If Student, Name of School ______________________ ☐ Full Time ☐Part Time

SPOUSE INFORMATION

Name ______________________
Address ______________ City __________ State ______ Zip __________
Home Phone # ______________ E-Mail: ______________
Driver's License # ______________ Soc. Sec. # ______________ Birthdate ______________
Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Employer's Name ______________________ Work Phone ______________
Work Address ______________ City __________ State ______ Zip __________
If Student, Name of School ______________________ ☐ Full Time ☐Part Time

PARENT INFORMATION *(If A Student)*

Name ______________________
Address ______________ City __________ State ______ Zip __________
Home Phone # ______________ E-Mail: ______________
Driver's License # ______________ Soc. Sec. # ______________ Birthdate ______________
Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated
Employer's Name ______________________ Work Phone ______________
Work Address ______________ City __________ State ______ Zip __________
If Student, Name of School ______________________ ☐ Full Time ☐Part Time

Person to contact in case of an emergency ______________________ Phone # ______________
Whom may we thank for referring you? ______________________
Do you have dental insurance? ☐Yes ☐No If so, please present insurance card.

Over Please

PATIENT MEDICAL HISTORY

Physician ______________________ Office Phone ________________ Date of Last Exam ______________

	Question	Yes	No
1.	Are you under medical treatment now?	❑	❑
2.	Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❑	❑

If yes, please explain ______________________________

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	Question	Yes	No
3.	Are you taking any medication(s) including non-prescription medicine?	❑	❑

If yes, what medication(s) are you taking? ______________

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	Question	Yes	No
4.	Do you use tobacco?	❑	❑
5.	Do you use controlled substances?	❑	❑
6.	Are you wearing contact lenses?	❑	❑

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	❑	❑	Heart Disease	❑	❑	Chest Pains	❑	❑
Heart Attack	❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded	❑	❑
Rheumatic Fever	❑	❑	Heart Murmur	❑	❑	Stroke	❑	❑
Swollen Ankles	❑	❑	Angina	❑	❑	Hay Fever/Allergies	❑	❑
Fainting/Seizures	❑	❑	Frequently Tired	❑	❑	Tuberculosis	❑	❑
Asthma	❑	❑	Anemia	❑	❑	Radiation Therapy	❑	❑
Low Blood Pressure	❑	❑	Emphysema	❑	❑	Glaucoma	❑	❑
Epilepsy/Convulsions	❑	❑	Cancer	❑	❑	Recent Weight Loss	❑	❑
Leukemia	❑	❑	Arthritis	❑	❑	Liver Disease	❑	❑
Diabetes	❑	❑	Joint Replacement or Implant	❑	❑	Heart Trouble	❑	❑
Kidney Diseases	❑	❑	Hepatitis/Jaundice	❑	❑	Respiratory Problems	❑	❑
AIDS or HIV Infection	❑	❑	Sexually Transmitted Disease	❑	❑	Mitral Valve Prolapse	❑	❑
Thyroid Problem	❑	❑	Stomach Troubles/Ulcers	❑	❑	Other ____________	❑	❑

8. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	❑	❑
Penicillin or any other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Any Metals (eg. nickel, mercury etc.)	❑	❑
Latex Rubber	❑	❑
Other ______________________	❑	❑

9. Women Only:

		Yes	No
A)	Are you pregnant or think you may be pregnant?	❑	❑
B)	Are you nursing?	❑	❑
C)	Are you taking oral contraceptives?	❑	❑

CANCELLATION POLICY

At least 24 hours notice is required to cancel an appointment that is scheduled for less than one hour. If my scheduled appointment is for more than one hour, I understand that 48 hours notice is necessary to cancel. If this policy is not adhered to, I understand there may be a charge based on the amount of time reserved for me.

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health care to third party payors and and/or health practitioners.

LATE CHARGES

Payment in full is required at each appointment. If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X______________________________

Signature of patient (or parent if minor)

Doctor's Comments ______________________________

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Signature ______________________ Date ______________