WHAT'S NEW

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ABOUT YOU

Today's Date: ____/_____/_____

Patient's Name: _____

SS #: _____-____-_____ Birthday: _____

Mailing address: _____ _____

_____

Cell Ph:(____) _____

E-mail Address: _____

In the event of an emergency, whom should we contact? _____

Phone #: _____

INSURANCE INFO

Has any of your Insurance Information changed? Y/N

Co. Name: _____

Member ID#: _____

Insured's Name: _____

Insured's SS # _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

*****Please provide any new Ins. Cards******

PLEASE LIST ALL MEDICATION CURRENTLY TAKING:

ALLERGIES, MEDICATION, DOSE & REASON: *****Use the back of page if more space is needed.*****

_____

_____

_____

_____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N ADHD/ADD
Y N Alzheimer's
Y N Anemia
Y N Angina
Y N Arthritis
Y N Artificial Heart Valves
Y N Artificial Joints
Y N Ascites
Y N Asthma
Y N A-Fib
Y N Back Problems
Y N Barrett's Esophagus
Y N Bleeding Problems
Y N Blood Disorder
Y N COPD
Y N Cancer/Tumor
Y N Celiac Disease
Y N Cerebral Palsy
Y N Chemical Dependency
Y N Chemotherapy
Y N Chronic Inflammation
Y N Chronic Pain
Y N Congestive Heart Failure
Y N Cometic Surgery
Y N Diabetic
Y N Dialysis
Y N Dizziness
Y N Epilepsy/Seizures
Y N Fainting
Y N Fibromyalgia
Y N Frequent Neck Pain
Y N GERD
Y N Gastric Bypass
Y N HIV+ / AIDS / ARC
Y N Hearing loss
Y N Heart Attack
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery
Y N Hepatitis (A,B,C)
Y N High Cholesterol
Y N High/Low Blood Pressure
Y N Jaw Pain/TMJ/TMD
Y N Kidney Problems
Y N Leukemia
Y N Liver Disease
Y N Lupis
Y N Mental Disorder
Y N Migraines
Y N Mitro valve Prolapse
Y N Multiple Sclerosis
Y N Nervousness
Y N Osteoporosis
Y N PTSD
Y N Pacemaker
Y N Paralysis
Y N Parkinson's Disease
Y N Pre-Diabetic
Y N Pregnancy
Y N Prostate Conditions
Y N Psoriasis
Y N Psoriatic Arthritis
Y N Radiation Treatment
Y N Red Dye Allergy
Y N Respiratory Conditions
Y N Rheumatic Fever
Y N Scarlette Fever
Y N Severe Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Sleep Apnea
Y N Smoker
Y N Stroke
Y N Tuberculosis
Y N Ulcers/Stomach Problems
Y N Venereal Disease
Y N Vertigo
Y N **Dementia (or a Version of it)
Y N **Trying to Conceive
Y N **IVF
Y N **IV Medications for Osteoporosis
Y N **Bisphosphonates
Y N **Blood Thinners
Y N OTHER_____

- To reduce our administrative costs and keep our fees as low as possible, we ask that you pay your estimated cost at the time of service.
- If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. ***We require 48 hours' notice for all rescheduled or cancelled appointments. Failure to do so may result in a $50 fee.***
- I have read & understand the privacy policy. I authorize the staff to perform any necessary services needed during diagnosis & treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____