PATIENT INFORMATION

REFERRED BY: _____ TODAY'S DATE: _____/_____/_____

LAST NAME: _____ FIRST NAME: _____ MI _____

BIRTHDATE: _____/_____/_____ AGE: _____ SS #: _____ - _____ - _____ SEX: M F MARITAL STATUS: S M D W

ADDRESS: | | | | | | | | | | | | | | | | | | | | | | | | | |

CITY: _____ STATE: _____ ZIP: _____ HOME #: (_____)_____

CELL #: (_____)_____ WORK #: (_____)_____ OCCUPATION:_____

May we leave confidential medical messages on your voice mail? YES NO PREFERRED PHONE: _____

PLEASE PROVIDE YOUR EMAIL FOR APPOINTMENT REMINDERS, PHYSICIAN/PATIENT RELATIONS, PROMOTIONS & E-NEWS.

EMAIL: | | | | | | | | | | | | | | | | | | | | | | | | | |

INSURANCE INFORMATION (*Skip if a copy of insurance card is available.*)

PRIMARY INSURANCE CARRIER: _____ PHONE: (_____)_____

POLICYHOLDER (NAME ON CARD) _____

ID#: _____ GROUP#: _____

IF YOU ARE NOT THE POLICYHOLDER, THEN WHAT IS YOUR RELATIONSHIP WITH THE POLICYHOLDER? _____

POLICYHOLER'S DATE OF BIRTH:_____/_____/_____ POLICYHOLDER'S SSN#: _____ - _____ - _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CELL #: (_____)_____ HOME #: (_____)_____ WORK #: (_____)_____

*IF YOU ARE A **MINOR**, THE INSTITUTE REQUIRES WRITTEN AUTHORIZATION FROM A LEGAL GUARDIAN THAT WE MAY CONDUCT A MEDICAL EXAM AND/OR TREATMENT WITHOUT THE PRESENCE OF A LEGAL GUARDIAN.*

TO BE COMPLETED BY THE LEGAL GUARDIAN

I AUTHORIZE _____ TO BE SEEN WITHOUT A LEGAL GUARDIAN PRESENT.

GUARDIAN NAME: _____ SIGNATURE: _____ DATE: _____

RELATIONSHIP: _____ CELL #: (_____)_____ HOME #: (_____)_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other:_____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other:_____

Skin Disease History: (please circle all that apply)

Acne
Asthma
Blistering Sunburns
Hay Fever/Allergies
Psoriasis
Eczema
Actinic Keratoses
Basal Cell Skin Cancer
Squamous Cell Skin Cancer
Melanoma
Precancerous Moles
Poison Ivy
Other:_____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?_____
Any other family history_____

Medications:
1._____2._____3._____4._____
5._____6._____7._____8._____

Allergies:
1._____2._____3._____4._____

Social History: (Please circle all that apply)
Cigarette Smoking: Never smoked Quit smoking Occasional Smoker Smokes daily
Illicit Drug Use:
Alcohol: None less than 1 drink a day 1-2 drinks a day 3 or more drinks

Alerts: (please check yes or no for the following)

Alert	Yes	No
Pacemaker/Defibrillator		
Artificial Joints requiring premedication		
Allergic reaction to lidocaine		
Allergic reaction to adhesive		
Allergic reaction to Neosporin/ Ointments		
Immunosuppresion		
Blood thinners		
Problems with bleeding		
Problems with healing		
Pregnancy or Planning on Pregnancy(Female)		