PATIENT INFORMATION

Patient Name:		Date:
Address:		
Home Phone:		Work Phone:
Date of Birth:		Age:
Social Security No:		Sex:
Marital Status:		Spouse's Name:
Occupation:		Employer or School:
Referring Physician:		Family Physician:
Emergency Contact:		Telephone:
Do you have a living will or health care proxy in writing?		Retirement or Disability Date:
Do you smoke?	How much?	Blood Type:
Do you drink alcohol?	How much?	Ever had a blood transfusion?

PRIMARY INSURANCE

Provider Name:	Issue Date:
Subscriber Name:	Relationship:
Subscriber DOB:	Social Security #
ID #	Group or Plan #
Employer & Address	
Provider Address:	
Provider Phone #	Co-Pays:

SECONDARY INSURANCE

Provider Name:	Effective Date:
Subscriber Name:	Relationship:
Subscriber DOB:	Social Security #
ID #	Group or Plan #
Employer & Address:	
Provider Address:	
Provider Phone #	Co-Pays:

PHARMACY

Pharmacy: ______________________________________ Telephone: __________________

Mail Order: ______________________________________ Telephone: __________________

ALLERGIES

Drug or Substance	Reaction

PRESCRIPTION DRUGS

Prescription Drug Name	Dosage	Frequency	Prescribing Physician	Brand/ Generic	Date started

OVER THE COUNTER DRUGS

OTC Drugs or Supplements	Dosage	Frequency	Recommending Physician	Date Started

MEDICAL HISTORY

Name: ____ **DOB:** __________________

Diagnosed Condition	Treatment	Physician	Health Center	Date

FAMILY MEDICAL HISTORY

Relationship and Maternal (M) or Paternal (P)	Diagnosed Condition(s)	Age of Diagnosis	Living or Deceased

SURGICAL HISTORY

Surgery or Procedure	Diagnosis	Physician	Hospital	Date

MISCELLANEOUS INFORMATION

Immunization or Procedure	Physician	Medical Center	Date

LIST OF CURRENT PHYSICIANS AND HEALTHCARE PROVIDERS

NAME	ADDRESS	CITY	STATE	ZIP	PHONE	SPECIALTY