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■ PATIENT INFORMATION ■

Ms./ Mrs. / Mr./ Dr.: _____

What name do you prefer to be called: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Soc.Sec. #: _____

Occupation: _____

Single / Married / Divorced / Domestic Partnered/Widowed/Significant Other

Employer: _____ Home #: ( ) _____

Work #: ( ) _____ Cell #: ( ) _____

Primary number: Cell/Home/Work Secondary number Cell/Home/Work

E-mail address: _____

Who referred you to our practice? ☐ Web: _____ ☐ Other _____

☐ Physician: _____ ☐ Patient _____

■ BILLING INFORMATION ■

Primary Ins. Carrier: _____

Policy Holder: _____ Relationship: _____

ID# _____ Group #: _____

Secondary Ins. Carrier: _____

Policy Holder: _____ Relationship: _____

ID# _____ Group #: _____

■ EMERGENCY CONTACT ■

Name: _____ Home Tel: _____

Relationship: _____ Work Tel: _____

What would you like to discuss with the doctor?: _____

I hereby authorize the doctors to furnish, to any designated party, all information necessary to file a health insurance claim. I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled by to any health plans, to the doctors.

I understand that I am personally responsible for payment of services rendered.

_____ _____

Signature of Insured or Guardian *Date*

▪ PERSONAL MEDICAL INFORMATION ▪

Patient's Name: _____ Date: _____

Age: _____ Height: _____ Weight: _____

Please answer all questions to the best of your ability. For items that do not apply, write "N/A".

List previous cosmetic and general surgeries and dates: _____

List previous hospitalizations and dates: _____

Please circle all of the following medical conditions that you now have, or have had in the past:

Asthma	High Cholesterol
Heart Murmur	Diabetes
High Blood Pressure	Depression/ Anxiety
Heart Attack	Auto-immune Disease
Stroke	Alcohol / Drug Dependency
Meningitis	Irregular Heartbeat
Hepatitis	Seizure Disorder
HIV	Eating Disorder
Bleeding/Brusing Problems	Steroid Use
Glaucoma	Nasal Allergies
Dry Eyes	Herpes / Cold Sores
Thyroid Problem	Breast Cancer/ BRCA Postive
Tuberculosis	Skin Cancer
Lung Disease	Other Cancer
Arthritis	Sleep Apnea
Anemia	DVT/Blood Clotting disorder
Latex Allergy	Blood Clots
Raynaud's disease/ phenomenon	Serious Accidents

Provide additional information if you have circled any of the above: _____

Do you have any allergies to any medications? Please list: _____

Please list all current medications, herbal supplements & vitamins / dosages: _____

Tobacco Use / History: _____

Alcohol Use (Drinks / Week): _____

Do you have any family history of breast cancer? YES? _____ NO? _____

Do you have any family history of heart disease? YES? _____ NO? _____

Do you use ASA/aspirin? _____

Do you use Motrin, Aleve, Naprosyn, or any non-steroidal anti-inflammatory medications? _____
If yes, when was your last use? _____

What is your exercise routine/ How often? _____

_____

When was your last physical examination? _____
Who examined you? _____

Have you or anyone in your family had problems with general anesthesia? If so, please describe:

_____

Do you wear: _____ Contact Lens _____ Glasses
_____ Hearing Aids _____ Dentures

WOMEN'S SECTION

Who is your OB/GYN?: _____

Ages of Children, if any: _____

Type of Delivery: _____

Is there any chance you may be pregnant at this time? _____ YES _____ NO

What form of birth control/protection do you use? _____

Date of Last Mammogram: _____ Facility Name: _____
Address: _____
Telephone #: _____

Current bra cup size: _____

Desired bra cup size (breast patients only): _____

Date of last PAP Smear: _____ Where taken: _____