



PATIENT INFORMATION

Please provide driver's license for us to copy. Male Female Single Married - Spouse's Name: Separated Divorced Widowed Other

Name: Last First Middle Prefer to be called (if different)

Address: Street City/State Zip

Phone: (H) (W) (Cell) Please note that numbers provided are used by this office to contact you or to leave messages.

Birthdate: Age: Social Security #: Email:

Employer: Occupation:

Employer Phone: Employer City:

Primary Care (Family) Physician: Physician Phone:

Physician Address: Street City/State Zip

How did you hear about us? (please mark all that apply)

- Radio - FISH/WHK/WTAM/WNIR Internet Search Patient Referral TV - Ch 19 "Health Connections" Facebook Ad Physician Referral YellowPages/YellowBook Sign Other

RESPONSIBLE (OR INSURED) PARTY INFORMATION

Name: Last First Middle Male Female

Address: Street City/State Zip

Phone: (H) (W) (Cell)

Birthdate: Social Security #: Relationship:

Employer: Phone: City:

INSURANCE INFORMATION

Please provide insurance cards for us to copy. PRIMARY SECONDARY

Insurance Company: Insurance Company:

Address: Address:

Phone #: Phone #:

Subscriber Name: Subscriber Name:

Relationship: Birthdate: Relationship: Birthdate:

Subscriber ID #: Subscriber ID #:

Group Name: Group Name:

Group #: Effective: Group #: Effective:

Notify in Case of Emergency EMERGENCY

Name: Last First Relationship: Phone:

Signature: Date:



MEDICAL HISTORY

Please check any of the following which you have or have had:

- Heart Attack/Angina, Asthma/Emphysema, Skin Disease\*, Alcoholism, etc.

\*please elaborate: \_\_\_\_\_

Other medical conditions: \_\_\_\_\_

MEDICATIONS

Please list any medications or vitamins taken regularly:

\_\_\_\_\_

Do you take any blood thinners? \_\_\_\_\_

Please list any allergies that you have: \_\_\_\_\_

SURGICAL HISTORY

Please list any surgeries that you have had (include dates):

\_\_\_\_\_

Do you have any implanted electronic devices such as a pacemaker or defibrillator? \_\_\_\_\_

FAMILY HISTORY

Table with 4 columns: Family member, Age, Health problems, If deceased.

Any family members with colon cancer or polyps in the colon? Yes No Who/Age? \_\_\_\_\_

SOCIAL HISTORY

- Do you smoke? Yes No Quit Packs per day Years
Do you drink alcohol? Yes No Quit Number of drinks per week
Do you use recreational drugs? Yes No Quit Type
Are you pregnant? Yes No Don't know

Signature: \_\_\_\_\_ Date: \_\_\_\_\_