Social Security Number: ________ - ______ - ________

Patient Name: ____ ______ - ______ - ___________ ________

Last **First** **Middle Initial** **Date of Birth** **Age**

Mailing Address: ____ **City:** ___________________ **Zip:** ________

Street Address: ____ **City:** ___________________ **Zip:** __________

Home Phone: ____________________ **Cell Phone:** _____________________ **Work Phone:** ___________________

Patient Employer: __________________________________ **Patient Occupation**______________________________

□ **Male** □ **Female** **Race:** ____________________ □ **Non Hispanic** □ **Hispanic** **Language:** ___________________

Email Address: ____

Pharmacy: ____ **City:** ________________________________

- **SPOUSE'S INFORMATION:**

Name: ____ **Social Security Number:** ________ - ______ - ________

Mailing Address: ____ **City:** ____________________ **Zip:** _________

Home Phone: _____________________ **Cell Phone:** _____________________ **Work Phone:** _________________

Date of Birth: ________ - _______ - __________ **Employer:** ____

- **RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT)** **Relation to Patient:** ______________________

Name: ____ **Social Security Number:** ________ - ______ - ________

Mailing Address: _______________________________________ **City:** ______________________ **Zip:** _________

Home Phone: _____________________ **Cell Phone:** ____________________ **Work Phone:** __________________

Date of Birth: _______ - ______ - __________ **Employer:** ____

- **EMERGENCY CONTACT PERSON:** (***<u>Must have phone number different than patient</u>***)

Name: ____ **Relationship:** ____________________________

Home Phone: ____________________ **Cell Phone:** ____________________ **Date of Birth:** ___________________

Referred by: _____________________________ **Previous Primary Care Physician:** _______________________

Reason for today's visit:

____

ALLERGIES

Check all that apply:

___ Bactrim / Septra / Sulfa
___ Cephalosporin (i.e. Ceftin, Cefzil, Keflex)
___ Codienes (i.e. Prescription Cough Syrup)
___ Codones (i.e. Norco, Lortab, Percocet)
___ Insulin
___ Iodine / Shellfish
___ Foods ________________________________

___ Latex
___ Penicillin
___ Tape/Adhesive
___ Pollens/Dust/Molds_______________________
___ Other _________________________________
___ Other _________________________________
___ Other _________________________________

PAST MEDICAL HISTORY

Check all that apply:

CONDITION	DO YOU SEE A SPECIALIST FOR THIS Y/N	PHYSICIAN / OFFICE	CONDITION	DO YOU SEE A SPECIALIST FOR THIS Y/N	PHYSICIAN / OFFICE
___ Abnormal Menses	____	____________________	___ Hepatitis (A, B or C)	____	____________________
___ Anemia	____	____________________	___ High Blood Pressure	____	____________________
___ Anxiety	____	____________________	___ High Cholesterol/Trig	____	____________________
___ Arthritis (unspecified)	____	____________________	___ Hyperthyroidism	____	____________________
___ Asthma	____	____________________	___ Hypothyroidism	____	____________________
___ Breast Cancer	____	____________________	___ Kidney Disease	____	____________________
___ Cervical Cancer	____	____________________	___ Kidney Stones	____	____________________
___ Chronic Acid Reflux (GERD)	____	____________________	___ Liver Disease	____	____________________
___ Colon Cancer	____	____________________	___ Lung Cancer	____	____________________
___ COPD	____	____________________	___ Polyps (Colon)	____	____________________
___ Coronary Artery Disease	____	____________________	___ Prostate Cancer	____	____________________
___ Deep Vein Thrombosis	____	____________________	___ Rheumatoid Arthritis	____	____________________
___ Depression	____	____________________	___ Seasonal Allergies	____	____________________
___ Diabetes Type 1	____	____________________	___ Stroke	____	____________________
___ Diabetes Type 2	____	____________________	___ Autoimmune Disease	____	____________________
___ Emphysema	____	____________________	___ Other _________________		____________________
___ Endometriosis	____	____________________	___ Other _________________		____________________
___ Fibromyalgia	____	____________________	___ Other _________________		____________________

Please list any medical issues not listed that you want us to be aware of:____

____

Office Policies

As a patient, you are ultimately responsible for your own care. This can be exhibited by knowing what medications you are taking and why, arriving on time for appointments, completing labs and tests that are ordered by your physician, and obtaining refills/completing paperwork in a timely manner. We will do our best to ensure we do our part by keeping you informed and complete your orders and prescriptions in a timely manner at your visit.

	Initials
Fees—Patients are expected to pay all co-pays at the time of your visit.	
Nurse calls and questions—Any non-scheduling questions will be routed to the nurse line. Please leave a message with the requested information and we will return your call within one business day.	
Appointment times—Please arrive early for your scheduled appointment. If you are late, you may be asked to reschedule.	
Cancellations—We request you give at least 24 hours of notice when cancelling an appointment. If you cancel or “no show” for 3 appointments, we reserve the right to NOT reschedule you for any future appointments.	
No show policy/Rescheduling—Patients that “no show” for 3 appointments are subject to dismissal from our practice for non-compliance.	
Conduct—Verbal or physical abuse of our physician or staff will NOT be tolerated for any reason or under any circumstance.	
Form completion—There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a $25 charge per form.	
Medication refills—refills need to be requested at least 3 days in advance. Ideally, these will be handled during your routine visits, but if you realize your medication needs to be refilled you may call and leave a message with the nurse requesting a refill.	

I understand and agree to these policies:

Date__________ Signature (patient/guardian)__________________________ Relationship_____________