

PATIENT DEMOGRAPHICS

Patient Name _____	Date of Birth _____	Sex _____
Address _____	City _____	State _____ Zip _____
Work Phone: _____	Home Phone: _____	Cell Phone: _____

How did you hear about us? _____

Insured Name _____	Date of Birth _____	SS# _____
Address _____	City _____	State _____ Zip _____
Work Phone _____	Home Phone _____	Cell Phone _____
Place of Employment _____		
Insurance Company _____		
E-Mail Address _____		

List any person(s) in which we may discuss your children's account (including school for excuses)

1. _____
2. _____
3. _____
4. _____

Physician Name _____ Phone _____

Pharmacy Name _____ Phone _____

PATIENT MEDICAL HISTORY

Medications:

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Y N Conditions

Is there any disease, condition, or problem that you think this office should know about that is not covered above?

If yes, please describe below...

Sex:

If female, please answer the following:

If female, please answer the following:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking Birth Control Pills?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	If yes, # of weeks <input style="width: 50px;" type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	

<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or use tobacco?	Height: <input style="width: 50px;" type="text"/>
For Office Use Only		BP <input style="width: 50px;" type="text"/>	Heart Rate: <input style="width: 50px;" type="text"/>
		Weight: <input style="width: 50px;" type="text"/>	

<table border="1" style="width: 100%;"> <tr><th>Y</th><th>N</th><th>Conditions</th></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>ADHD</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Bleeding</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anemia</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Bones</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Artificial Heart Valve</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Autism</td></tr> <tr><td><input type="checkbox"/></td><td><input 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Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)