WELCOME

ABOUT YOU

Today's Date:________________

Name: _________________________________Nickname: _____________Male Female

Address: ____Zip__________________

Home Phone #:(___)___________________ **Email Address**_______________________

Cell Phone #:(___)___________________ Work Phone #:(___)__________________

Birthdate:___/___/______ Marital status__________ SS#______________________

Whom may we thank for referring you:____

Employer:_______________________________Policy Holder's name:_________________

Policy Holder's Birthdate___/___/____ Policy Holder's SS#______________________

Insurance Company:______________________ Group (Plan/Policy#)_________________

Address:__________________________________ Insurance Phone #:(___)__________

Medical History

Are you now or have you recently been under a physician's care? _________ yes _________ no

Reason____

Check any of the following medical conditions you may have had:

___Arthritis	___Hepatitis or Jaundice	___Prolonged bleeding
___Rheumatic Fever	___Liver Disease	___Fainting tendency
___Heart trouble	___Cancer or Tumor	___Epilepsy
___Heart Murmur/MVP	___Tuberculosis	___Thyroid Disease
___High/Low blood Pressure	___Diabetes	___Radiation treatment
___Chest Pain	___Mental disorders	___Stroke
___Kidney/bladder trouble	___HIV or AIDS	___Shortness of Breath
___Anemia	___Prosthetic joint replacement	___Asthma or Hay fever
___Lung Disease	___Blood Disease	___Sinus Trouble
___Venereal Disease	___Blood transfusion	

Are you allergic to anything? ___yes___no If yes, please list_____________________________

Are you taking any medications? ____yes____no If yes, please list_____________________________

Are you pregnant? ____yes ____no If yes, how many months?_____Are you breast feeding?_____

Patients signature:____ Date:_______________

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