

PATIENT INFORMATION

DATE _____ (PLEASE PRINT ON ALL OF THE FORMS)

Name _____ Soc. Sec. # _____ - _____ - _____

Address _____ City _____ State _____ Zip code _____

Home Phone # _____ Cell phone # _____

E-mail Address _____ Sex - M F Birthday _____ / _____ / _____ Age _____

How did you hear about us? _____ Status: Single Married Widowed Separated Divorced

Employer _____ Occupation _____

Business Address _____ Work Phone _____

In case of an emergency, whom shall we notify? _____ Phone _____

FIRST OR PRIMARY INSURANCE INFORMATION

Insurance Co. _____ Ins. Phone# _____

Ins. Address _____ State _____ Zipcode _____

ID or Subscriber # _____ Group # _____

SUBSCRIBERS Name _____ Relationship to the Patient _____

Birth date _____ / _____ / _____ Soc. Sec. # _____ - _____ - _____ Home Phone # _____

Address _____ Work Phone# _____

Employer _____ Occupation _____

SECOND OR ADDITIONAL INSURANCE

Insurance Co _____ Ins Phone # _____

Ins. Address _____ State _____ Zipcode _____

ID or Subscriber # _____ Group # _____

SUBSCRIBERS Name _____ Relationship to the patient _____

Birthday _____ / _____ / _____ Soc. Sec. # _____ - _____ - _____ Home Phone _____

Address _____ *Work Phone _____

Employer _____ *Occupation _____

RELEASE

I the undersigned, certify that I (or my dependents) have insurance coverage with _____ and assign Dr. **Hammonds** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of insurance submissions.

Responsible party signature _____ Date _____ Relation to patient _____

Primary care Physicians name (first) _____ (last) _____ Phone # _____

Medical Information

Patient Name _____ D.O.B. _____

Mark all that apply:

- ___ Gout ___ Fainting ___ Heart Problems ___ High Blood Pressure ___ Asthma
- ___ Anemia ___ Arthritis ___ Kidney Problems ___ Shortness of Breath ___ Hay fever
- ___ Cancer ___ Epilepsy ___ Tuberculosis ___ Bleeding Disorders ___ Muscular Disorders
- ___ Difficulty Hearing ___ Smoker ___ Ulcers ___ Stomach Problems ___ Circulation Problems

Are you a diabetic? Yes No What type? Type I Type II How long have you been diabetic? _____

Are there any medical problems in your family? _____

TODAY'S PROBLEM: _____

Surgeries and Hospitalizations

Year: Hospital: Reason for hospitalization and outcome:

Medications

Please list any medications that you are currently taking: _____

Allergies

Please mark any medications that you are allergic to and list the reaction you had to the medicine.

- ___ Penicillin _____ ___ Novocaine _____ ___ Codeine _____
- ___ Local Anesthesia _____ ___ Tape _____ ___ Aspirin _____
- ___ Mercurials _____ ___ Sulfa Drugs _____ ___ Other Antibiotics _____

Health and Occupational Habits

Check all that apply and specify amount per day:

- ___ Caffeine _____ ___ Alcohol _____ ___ Tobacco _____

Check if your work exposes you to the following:

- ___ Stress ___ Heavy lifting ___ Hazardous substances

Pharmacy Name and # _____ Primary care physician _____

I certify that all of the above knowledge is true and to the best of my knowledge. I do not hold the staff or doctor responsible for any errors I have made.

Signature _____ Date _____