UPDATE

1 PERSONAL INFO

Today's Date: ______/______/______ D.O.B: ______________

Patients Name: ______________________________
LAST FIRST MI

SS# ______________________________

Mailing Address: ______________________________
☐ UNCHANGED

____
CITY STATE ZIP

Home Phone #:(_____) ______________________________

(_____) ______________________ (_____) ______________________
OFFICE PHONE EXT. CELL PHONE

E-mail Address: ______________________________

Employer / School: ______________________________
☐ FULL TIME STUDENT

Employer's/School's Address: ______________________________

____
CITY STATE ZIP

Occupation: ______________________________

Marital Status: ______________________________

Spouse's Name: ☐ UNCHANGED

2 INSURANCE INFO

Has any of your Insurance Information changed? ☐ No ☐ Yes
If your Insurance info has not changed, please continue on to section 3

Ins. Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: (_____) ______________________________

Insured's ID # or SS#: ______________________________

Group # (Plan, Local or Policy #): ______________________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth: ___/___/___

Insured's Employer: ______________________________

________ I hereby authorize assignment of my insurance
Initials rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please provide any *new* Primary / Secondary Ins. Cards with this form.

3 MEDICAL HISTORY

Physician ______________________ *Office Phone* *Date of Last Exam* ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain. ______________________________		
3. Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? ______________________________		
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Are you wearing contact lenses?	☐	☐

9. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) ______________	☐	☐
10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
11. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

8. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	*Heart Disease*	☐	☐	*Chest Pains*	☐	☐
Heart Attack	☐	☐	*Cardiac Pacemaker*	☐	☐	*Easily Winded*	☐	☐
Rheumatic Fever	☐	☐	*Heart Murmur*	☐	☐	*Stroke*	☐	☐
Swollen Ankles	☐	☐	*Angina*	☐	☐	*Hay Fever / Allergies*	☐	☐
Fainting / Seizures	☐	☐	*Frequently Tired*	☐	☐	*Tuberculosis*	☐	☐
Asthma	☐	☐	*Anemia*	☐	☐	*Radiation Therapy*	☐	☐
Low Blood Pressure	☐	☐	*Emphysema*	☐	☐	*Glaucoma*	☐	☐
Epilepsy / Convulsions	☐	☐	*Cancer*	☐	☐	*Recent Weight Loss*	☐	☐
Leukemia	☐	☐	*Arthritis*	☐	☐	*Liver Disease*	☐	☐
Diabetes	☐	☐	*Joint Replacement or Implant*	☐	☐	*Heart Trouble*	☐	☐
Kidney Diseases	☐	☐	*Hepatitis /Jaundice*	☐	☐	*Respiratory Problems*	☐	☐
AIDS or HIV Infection	☐	☐	*Sexually Transmitted Disease*	☐	☐	*Mitral Valve Prolapse*	☐	☐
Thyroid Problem	☐	☐	*Stomach Troubles / Ulcers*	☐	☐	*Other* ______________	☐	☐

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any further changes to the information I have provided.

Signature ______________________________ Date: ________ / ________ / ________