

PATIENT HEALTH HISTORY

PATIENT'S NAME _____ DOB: _____ AGE: _____ SEX: _____

HM ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HM PHONE:(____) _____ WK PHONE:(____) _____ CELL#:(____) _____

SSN#: _____ MARTIAL STATUS: _____

EMPLOYER NAME AND ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

STUDENTS/NAME OF SCHOOL _____ FULL TIME: ____ YES ____ NO

RESPONSIBLE PARTY/SPOUSE'S NAME: _____ SSN#: _____

HM ADDRESS: _____

HM PHONE# () _____ WK PHONE#:() _____ CELL#:() _____

INSURANCE:

PLAN NAME: _____ PHONE#:(____) _____

CLAIM MAILING ADDRESS: _____

INSURED'S NAME: _____ DOB: _____

SSN/ID# _____ GROUP/PLAN# _____

PLAN NAME: _____ PHONE#(____) _____

CLAIMS MAILING ADDRESS: _____

INSURED'S NAME: _____ DOB: _____

SSN/ID# _____ GROUP/PLAN# _____

FOR BIOPSY, WE SEND TISSUE TO UT PATHOLOGY – IF YOUR INS REQUIRES ANOTHER LAB BE USED, PLEASE INDICATE HERE LAB NAME _____

The above insurance plan(s) are to be filed for today's services, and I certify that I have provided all insurance for claim filing. PLEASE BE ADVISED that if you have chosen not to provide us with your insurance information at the time of the service and you then choose to file the claim yourself at a later date, you are waiving any contractual agreements made with the insurance company.

SIGNATURE: _____ DATE: _____

** Due to the new Health Information Privacy Act, please list 2 people you authorize this office to contact in case of emergency and/or to leave message regarding your care.

NAME: _____ PHONE#:(____) _____ RELATIONSHIP: _____

NAME: _____ PHONE#:(____) _____ RELATIONSHIP: _____

REFERRED BY: _____

Do you need a school or work excuse? _____

MEDICAL HISTORY

Are you **ALLERGIC** to any medications or drugs? _____ If so what? _____

Are you presently taking any medications? _____ If so, List all medications here:

Have you ever been hospitalized? _____ If so, why? _____

Are you under the care of a physician? _____ If so, why? _____

Name of attending physician: _____

Do you or have you ever had any of the following?(**CIRCLE ALL THAT APPLIES TO YOU**)

- | | | | |
|-------------------------------|---------------------|---------------------|-----------------|
| Heart Disease | High Blood Pressure | Lung Disease | Diabetes |
| Alzheimer's | Rheumatic Fever | Kidney Disease | Thyroid Disease |
| Seizures | Heart Murmur | Liver Disease | Tuberculosis |
| Venereal Disease | Asthma | Hepatitis/Type ____ | |
| Bleeding Disorder | HIV Positive/AIDS | Cancer | |
| Mental or Emotional Disorders | | Breast Feeding | |

Have you had radiation treatment to the face or neck? _____

If Female, are you pregnant? _____

Reason for seeking treatment today? _____

In your opinion what is your current state of health? _____

I CERTIFY THAT I HAVE NOT HAD ANYTHING TO EAT OR DRINK IN THE LAST (6) HOURS.

Signature(parent, if a minor) _____ Date: _____