ESTABLISHED PATIENT-

Name: _____ Primary Doctor: _____

Today's Date: _____ Referring Doctor: _____

Date of Birth: _____ Gender: M / F

Marital Status: (circle one): single / married / widowed /divorced

Race (circle one):
American Indian/Alaska Native
Asian
Black or African American
Native Hawaiian/Pacific Islander
White
Decline to Report

Ethnicity (circle one):
Hispanic or Latino
Non Hispanic or Latino
Decline to Report

Language (circle one)
English / French / Spanish
Other: _____

Nationality (circle one):
American
African-American
Hispanic
other

Social Security Number: _____
Mother's Maiden Name: _____
Phone No. (1): _____(home)(cell)(work)
Phone No. (2): _____(home)(cell)(work)
Emergency contact : _____Phone No.(3)_____ (home)(cell)(work)

RECENT CHANGES, if any:

Address: _____
_____
_____

Primary Insurance:
Insurance Company: _____
ID Number:_____
Group Number: _____
Primary Insurance Holder Name: _____ DOB _____
Relationship to Patient_____

Secondary Insurance:
Insurance Company: _____
ID Number:_____
Group Number: _____
Primary Insurance Holder Name: _____ DOB _____
Relationship to Patient_____

Name: _____

PHARMACY: Please give the name , street & town. This is used for electronic prescriptions.

_____

_____

□ Please check this box to give us permission to access the electronic pharmacy database.

Recent:

Weight _____lb. Height ___ft.____ in.

Blood Pressure _____/_____ (approximate)

Have you had a recent CBC (blood count) When?_____ Where?_____

Have you had a recent EKG? When?_____ Where?_____

To Whom do you want to send results? _____

MEDICATION LIST

Please list **all** your medications and dosage

_____

_____

_____

_____

_____

_____

List any changes in medical history or recent surgery, & approximate date(s)

□ Hypertension _____ □ Diabetes _____ □ Heart problems _____

_____

_____

_____

_____

Allergies:_____

_____

_____

Briefly, why are you here today :

_____

_____