



Patient Information Form

Date: _____

Patient name: Last: _____ First : _____

Home address: _____

City, State Zip: _____

DOB: ___/___/___ Age: _____ Sex: Male Female SS#: _____ - _____ - _____

Home phone: (____)-____-____ Work Phone: (____)-____-____

E-mail address: _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, please notify: _____

Phone number: (____)-____-____

INSURANCE INFORMATION:

Medical insurance: _____ Policyholder: _____

Policy #: _____ Employer: _____

Relationship to patient: (Please check one) Self Spouse Child Other

Are you pregnant? (Please check one) Yes No How Many Months? _____

How many Pregnancies? _____ How many children? _____

Weight _____ Height _____

MEDICAL HISTORY:

ILLNESS / MEDICAL CONDITION: (Check all that apply)

- Diabetes Heart Hepatitis Epilepsy
- Cancer Thyroid Bleeding Alcoholism
- Depression Drug Abuse Asthma Bronchitis
- Arthritis Tuberculosis Glaucoma High Blood Pressure

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ALLERGIC REACTIONS: (Check all that apply)

- Anesthesia Penicillin Suffer Codeine
 Aspirin Antibiotics Demerol Iodine

Food Allergies: (Please check one) Yes No Please Specify _____

Other Allergies: (Please check one) Yes No Please Specify _____

FAMILY MEDICAL HISTORY:

- Diabetes Heart Glaucoma
 Cancer Tuberculosis Heart
 Asthma Bleeding High Blood Pressure

Other illnesses or medical problems: _____

Do you smoke? Yes No How many cigarettes a day? _____

Do you drink alcoholic beverages? Yes No How often? _____

Do you bruise easily? Yes No

List any previous surgeries, including plastic surgeries: _____

List all medications you are currently taking: _____

Reason for visit: _____

Referred by: _____

I certify that the above information is correct to the best of my knowledge.
I will not hold my doctor or any member of his office staff responsible for any error or omission that I may
have in the completion of this form.

Patient Signature: _____ Date: _____