Patient Demographics

Date ____________________

Patient Information:

First Name	Middle Name / MI	Last Name	Sex
Date of Birth	Home Phone	Cell Phone	Preferred Phone
Patient Address Line 1	Patient Address Line 2		
City	State *	Zip	
Email	Language	Communication Preference	Ethnicity
Religion	Race	Marital Status	
Spouse's Name	Spouse's Contact Phone		
Patient Employment Status	Professional Title	Employer Name	
Work Phone	Fax Number		
Employer Address Line 1	Employer Address Line 2		
Employer City	Employer State	Employer Zip	

Primary Insurance Information:

Primary Insured's Name	Date of Birth	Primary Relationship to Insured	Primary Insured's SSN
Insured's Home Phone	Cell Phone	Work Phone	Driver's License #
Primary Insurance Name	Primary Plan Name	Primary Subscriber ID	Primary Group No.

Secondary Insurance Information:

Secondary Insured's Name ______________________

Date of Birth ______________________

Secondary Relationship to Insured ______________________

Secondary Insured's SSN ______________________

Insured's Home Phone ______________________

Cell Phone ______________________

Work Phone ______________________

Driver's License # ______________________

Secondary Insurance Name ______________________

Secondary Plan Name ______________________

Secondary Subscriber ID ______________________

Secondary Group No. ______________________

Emergency Contact:

Emergency Contact Name ______________________

Emergency Contact Relationship to Patient ______________________

Emergency Contact Home Phone ______________________

Emergency Contact Cell Phone ______________________

Emergency Contact Work Phone ______________________

Emergency Contact Address Line 1 ______________________

Emergency Contact Address Line 2 ______________________

Emergency Contact City ______________________

Emergency Contact State ______________________

Emergency Contact Zip ______________________

Primary Physician Name ______________________

Primary Physician Phone ______________________

Whom may we thank for referring you? ______________________

Health History

Current medical conditions:

Month/Year Diagnosed	Medical Problem	Treatment/Medication
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Surgeries:

Month/Year	Reason	Hospital

1)	_	_
2)	_	_
3)	_	_
4)	_	_

Hospitalizations:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Medications:

Name of Drug	Strength	Frequency Taken
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Allergies

Name	Reaction
1)	_
2)	_
3)	_
4)	_

Exercise:

Type ____________ **Intensity** ____________ **Frequency** ____________

Type ____________ **Intensity** ____________ **Frequency** ____________

Social History

Caffeine:

Caffeine Beverage?

- Yes
- No

Type (coffee, tea, soda, etc.) ____________ **Amount** ____________ **Frequency** ____________

Alcohol:

Alcoholic Beverage?

- Yes
- No

Frequency ____________ **Amount** ____________

Smoking Status

Patient Smoking Status ____________ **Patient Smoking Frequency** ____________ **Patient Smoking Start Date** ____________ **Patient Smoking End Date** ____________

Do you currently use recreational or street drugs?

- Yes
- No

Have you ever given yourself street drugs with a needle?

- Yes
- No

Family History

List medical illness and/or cause of death:

Mother

____

Father

Brother/Sister

Husband/Wife

Son/Daughter

Additional Comments

Date

Signature of Responsible Party