

Welcome

ABOUT YOU

Today's Date: _____ E-Mail Address: _____ Patient ID #: _____

Name: _____ I prefer to be called: _____ Male Female
Last First MI Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Pager/Car #: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

FAMILY HISTORY

Family Health History

Relationship	Age, if Living	Age at Death & Cause of Death
Mother	_____	_____
Father	_____	_____

Siblings (specify which gender)	Age, if Living	Age at Death
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical Problems

Please identify any medical problems blood relatives have or ever have had.

<u>Condition</u>		Family Member(s)
Birth Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Genetic Defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mental Retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lung Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Condition

Bone/Joint Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Muscle Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Eye or Ear Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Anemia/Blood Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Kidney Disease/Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Seizures/Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mental Disease/Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Venereal Disease (VD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

