Patient Information

Date of Office Visit: **Name FIRST:** **MI:** **LAST:**	**DOB:** **Age:** **Sex: M F**
Address:	**Phone:** **SS#** **Cell Number:**
City: **State:** **Zip:**	**Employment:**
Race: **Ethnicity:** **Language:**	**Employer:** **Phone:**
Marital Status:	**Pharmacy:** **City:**
Primary Care Physician:	**Parent / Guardian:** **DOB:**

Please Bring Insurance Cards to your Appointment

Insurance Company:	**Policy #:** **Group#:**
Primary Subscriber : **Relationship to Subscriber: Spouse Self Child**	**DOB:**
Secondary Insurance:	**Policy #:**
Secondary Subscriber:	**DOB:**

Please List Current Medications (*Dosages and Times Taken)* *May use the back or attached list*

Name of Medication	Dosage	How often taken

Please list any medications allergies — Reaction

Previous Surgeries (Please include dates)

Have you had any problems with anesthesia (numbing or put to sleep) _____Yes _____ No

If yes, please list problems: _____

Please list non-surgical hospitalizations *(reason and date)*

_____

Other History

Have you had a pneumonia vaccine? ___Yes (Date) _____, ___No

Have you had a colonoscopy cancer screening? ___ Yes (Date) _____, ____No

Reason for today's visit (Please list when symptoms started and any other pertinent information)
