PATIENT HISTORY INFORMATION

DATE______________________

NAME:
Mr, Ms, Mrs, Miss ____
(Last) (First) (Middle)

ADDRESS: ____
(Street/Apt. #) (City) (State) (Zip Code)

DATE OF BIRTH: ______-______-______ AGE: ________ SOCIAL SECURITY#: _________-________-_________

HOME PHONE # : __________________________ CELL PHONE # : ______________________
(INCLUDE AREA CODE) (INCLUDE AREA CODE)

CONTACT PREFFERENCE: HOME CELL WORK (CIRCLE ONE)

STATUS: Single _________ Married __________ Other (Please Specify) ____________________

Employed ______ Full Time Student ______ Part Time Student _______ Other _________________

☐ EMPLOYER'S OR ☐ SCHOOL NAME: ____

ADDRESS: ____

PHONE: ____

☐ SPOUSE OR ☐ PARENTS NAME: ____

☐ SPOUSE OR ☐ PARENTS DATE OF BIRTH: ____

☐ SPOUSE OR ☐ PARENTS SOCIAL SECURITY NUMBER: ______________________________

☐ SPOUSE OR ☐ PARENTS EMPLOYER NAME: ____

ADDRESS: ____

PHONE: ____

EMERGENCY CONTACT (OTHER THAN LISTED ABOVE): ____
(NAME) (PHONE #)

MY PERMISSION IS GIVEN TO RELEASE ANY MEDICAL INFORMATION TO: (NAME/RELATIONSHIP)

____

NAME OF PRIMARY INSURANCE COMPANY: ____

NAME OF SECONDARY INSURANCE COMPANY: ____

*** PLEASE SIGN***

- I hereby authorize the physician to release any information acquired in the course of my examination or treatment to my insurance company. I certify that the information completed and furnished by me is correct.
- I hereby assign and direct my insurance to pay without further notice from me to the physician.

x____

REFERRED BY/ PRIMARY CARE PHYSICIAN: ____
(NAME, ADDRESS & PHONE NUMBER)