Date ________________

PATIENT INFORMATION

(Please Print)

MR. / MRS. / MISS ____

LAST NAME FIRST NAME MIDDLE

____

SOCIAL SECURITY NO. DATE OF BIRTH AGE DRIVERS LIC. #

____

ADDRESS STREET APT. # CITY STATE ZIP

____

HOME PHONE CELL PHONE BUSINESS PHONE

____

EMPLOYED BY EMPLOYER'S ADDRESS OCCUPATION

____

SPOUSE'S NAME EMPLOYED BY EMPLOYER'S ADDRESS

____

BUSINESS PHONE OCCUPATION

____

NEAREST FRIEND OR RELATIVE NOT RESIDING WITH YOU PHONE

THERE WILL BE A $200.00 CHARGE FOR NEW PATIENTS WHO FAIL TO GIVE A 24 HOUR NOTICE OF CANCELLATION

RESPONSIBLE PARTY: PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR PAYMENT.

____

NAME ADDRESS CITY STATE ZIP

____

HOME PHONE RELATIONSHIP TO PATIENT OCCUPATION

____

EMPLOYER ADDRESS CITY STATE ZIP

____

PHONE

METHOD OF PAYMENT: CASH _____ CREDIT CARD (VISA OR OTHER) _____ CHECK _____

WHOM MAY WE THANK FOR REFERRING YOU TO MY OFFICE ______________________________

WHAT ARE WE SEEING YOU FOR TODAY ______________________________

MEDICAL INFORMATION

Please answer questions by checking the appropriate box.

DO YOU HAVE ANY ALLERGY TO:

Medications or Drugs (if yes, specify below)	☐ Yes	☐ No
Ointments, Creams, or Lotions	☐ Yes	☐ No
Make-up or Jewelry	☐ Yes	☐ No

I am allergic to: ______________________________

DO YOU OR ANYONE IN YOUR FAMILY SUFFER FROM:

Hay Fever	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Sinus problems	☐ Yes	☐ No
Eczema	☐ Yes	☐ No

(If yes, specify who has it) ______________________________

DO YOU HAVE A HISTORY OF:

Heart Disease	☐ Yes	☐ No
Blood Pressure problems	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Bowel Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Vaginal Infections	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Bleeding problems	☐ Yes	☐ No
Skin Cancer	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Connective Tissue Disease	☐ Yes	☐ No
Other Skin Disease (If yes, specify below)	☐ Yes	☐ No

____

____

Do you drink alcoholic beverages? ☐ Yes ☐ No

(If yes, how many drinks a day?) __________

Do you smoke? ☐ Yes ☐ No

(If yes, how much?) ______________________________

Please list the name of any medication you are currently taking (including vitamins and birth control pills). ______________________________

____

Please list the name and approximate date of any operation you have had.

____

Do you currently use a form of birth control? ☐ Yes ☐ No

(If yes, what type?) ______________________________

SIGNATURE ______________ ______________________