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Name _____ Date ____/____/____

Birthdate ____/____/____ Gender M F

Local Home Address _____

Out Of Town Address _____

Preferred phone # _____ Home Cell

Secondary phone # _____ Home Cell

Email address: _____

Providing an email address allows the patient electronic access to their Patient Health Record. This information is password protected and available only to the patient.

Preferred method of communication: Home phone Cell phone
 Email Snail mail

May we leave a voicemail? Yes No

With whom may we leave messages? Spouse/partner Daughter/son
 Aide Other: _____

Emergency Contact:

Name _____ Relationship _____

Phone # _____

How did you hear about us?

Insurance directory Internet/Google Advertisement
 Doctor _____ Friend _____

Primary physician _____

List of medications/supplements:

Name	Dosage

Allergies (check all that apply):

- No Known Allergies
- Penicillin
- Aspirin
- Latex
- Sulfa
- Other: _____
- Codeine
- Contrast dye
- Topical iodine
- Adhesive tape
- Shellfish

Smoking status:

- Never smoked
- Currently smoke How much? _____
- Previously smoked Quit date _____

Height _____

Weight _____

Shoe Size _____

When was your last flu shot? ____/____/____

Have you received a pneumococcal vaccine? Yes No

Have you fallen in the last 12 months? Yes No

If yes, were you injured from the fall? Yes No

Medical history (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cancer (please specify):
_____ | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> CHF/heart failure | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Crohn's/colitis | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Diabetes (insulin) | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Diabetes (non- insulin) | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> Thyroid disease |

Surgical history (check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Cardiac stents | <input type="checkbox"/> Open heart surgery |
| <input type="checkbox"/> Leg stents | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Foot surgery: _____ | |
| <input type="checkbox"/> Other surgery: _____ | |

The information I provided above is accurate and answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and/or office staff of any changes to this information.

Signature _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices and Authorization of Benefits

I acknowledge that I was provided a copy of the Notice of HIPAA Privacy Practices, and that I have (or have the opportunity to read if I so choose) and understand the Notice. I authorize payment of medical benefits to the practice named above. I authorize release of medical information necessary to process this claim. I authorize the doctor's office to retrieve my medication history. I understand that I am financially responsible for any balance due to my account. Additionally, I hereby consent to any treatment as deemed necessary by the doctor(s).

Patient name _____

Authorized Representative (if applicable) _____

Signature _____ Date _____