PATIENT INFORMATION

Date:____________

NAME:____

(Last) (First) (Middle)

ADDRESS:____

City, State: ______________________________________ Zip Code:________________

Male ____ Female____Social Security #________________ DOB:_________ Age:_______

Phone: __________________ Work Phone: _________________ Cell:________________

Employer:_________________________Occupation:______________________________

Spouse's Name:___________________ Spouse's Employer: _______________________

Contact Person:___________________Relationship:_____________Phone:_____________

1. Name **Primary** Insurance:____

2. Name **Secondary** Insurance:____

I am: (Check One) the insured_______, insured's spouse_______, insured's child___________

I will be paying today by: **Cash**_______ **Check**______ **VISA/Mastercard**____________

Do you take aspirin daily: Yes____ No ____ Do you take a blood thinner? Yes____ No ____

Have you had joint replacement? Yes____ No___

Are you allergic to local anesthesia?(Xylocaine, Novacaine) Yes____,No_____

Are you allergic to any medications? Yes____ No____

List medications to which you are **allergic**: **List the medications you are taking:**

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

____________________________ ____________________________

Are you under the care of a physician for a medical condition? Yes_______ No______

Your Primary Care Physician:____

____

Minors Only: (Under the age of 18 years)

Mother's name_______________________ Father's Name______________________

DOB: _________ SS#:________________ DOB:_________SS#:_________________

Address:____________________________ Address: __________________________

____________________________________ ____________________________________

Work #:____________________ Work #: _________________________