

This form must be properly completed and signed before you will be allowed to see the doctor.

Name: _____ Age: _____ Date of Birth: _____
Last First Middle

Address: _____ City: _____ ST: _____ Zip: _____

Social Security No: _____ Driver's License No: _____

Phone: _____ Marital Status: M S W D Name of Spouse: _____

Responsible Party: _____
Name Address Home Phone Business Phone

Employer: _____
Mr: Name Address Phone

Mrs: Name Address Phone

Nearest Relative Not Living With You: _____
Name Address Phone

In Case of Emergency: _____
Name Address Relationship

Home Phone Business Phone

Referred By: _____

Insurance Carrier Name: _____ Policy #: _____

Policy Holder Name: _____ SSN: _____ Date of Birth: _____

Secondary Carrier Name: _____ Policy #: _____

Policy Holder Name: _____ SSN: _____ Date of Birth: _____

FISCAL POLICY:

- 1) You, the undersigned responsible party, agree to be responsible for all fees/charges incurred for services provided by this office. We will file your insurance only if the following applies:
 - a) You belong to one of our HMO, PPO, BCBS, or other health plans.
 - b) **Medicare Patients:** We are a participating provider. Your charges will be filed with Medicare and your secondary insurance. You are responsible for your deductible and 20% of the allowable charges.
- 2) **Payment is expected at time of service.** A receipt will be provided for you to file with your insurance company.
- 3) All accounts not paid within a reasonable time may be referred to a collection agency.
- 4) We do not get involved in any way with disputes between divorced parents of a child we are treating. If you bring the child for treatment, you are responsible for payment in full for services rendered. **We do not bill the other parent.** We will, however, provide additional copies of your child's bill should you need it.

I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS OR TOHER INFORMATION TO PROCESS INSURANCE CLAIMS OR ANY BENEFITS DUE MY PROVIDER. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PROVIDER AT THIS OFFICE FOR SERVICES RENDERED TO ME. I UNDERSTAND THAT IF THE PHYSICIAN IS NOT PAID IN FULL BY PROCEEDS OF ANY BENEFITS, THEN THIS ASSIGNMENT DOES NOT RELEASE MY OBLIGATION AND LIABILITY TO THE PHYSICIAN FOR PAYMENT OF ALL SERVICES AND ITEMS PROVIDED TO ME.

Signature of Patient OR Patient's Authorized Representative

Date

Review of Systems

Patient Name: _____ **Date:** ____/____/____

Do you now or have you had any symptoms related to the following systems? Circle "Y" (Yes) or "N" (No).

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other:	_____	

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent Itch	Y	N
Other:	_____	

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other:	_____	

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other:	_____	

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other:	_____	

Ear / Nose / Throat / Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problem	Y	N
Other:	_____	

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other:	_____	

Genitourinary

Urine retention	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other:	_____	

Endocrine

Excessive thirst	Y	N
Too hot / cold	Y	N
Tired / sluggish	Y	N
Other:	_____	

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other:	_____	

Gastrointestinal

Abdominal pain	Y	N
Nausea / Vomiting	Y	N
Indigestion / heartburn	Y	N
Other:	_____	

Hematologic / Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other:	_____	

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N

Psychologic

Are you generally satisfied with your life?	Y	N
Do you feel severely depressed?	Y	N
Have you considered suicide?	Y	N

Last Eye & Dental Exam

Date – Last Eye Exam: ____/____/____

Date – Last Dental Exam: ____/____/____

Sexual History

Change in sex drive?	Y	N
Sexual performance satisfactory?	Y	N
Other (i.e. sexual trauma)	_____	

Physician use only: (Comments / Notes)