

**PATIENT INFORMATION FORM**

DR. MR. MRS. MISS MS. \_\_\_\_\_ DATE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ ALTERNATE PHONE \_\_\_\_\_

(PLEASE CIRCLE)                      WORK                      CELL

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

GENDER: M F    MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNER

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

FULL-TIME \_\_\_\_ PART-TIME \_\_\_\_ FULL-TIME STUDENT \_\_\_\_ PART-TIME STUDENT \_\_\_\_ RETIRED \_\_\_\_

PRESENT MEDICAL CONDITION(S) \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

ALLERGIES TO MEDICATIONS \_\_\_\_\_

ALCOHOL USE:    \_\_\_\_ NONE                      \_\_\_\_ OCCASIONAL                      \_\_\_\_ DAILY

TOBACCO USE:    \_\_\_\_ NONE                      \_\_\_\_ OTHER                      RECREATIONAL DRUG USE:    YES    NO

INITIAL \_\_\_\_    DATE \_\_\_\_                      INITIAL \_\_\_\_    DATE \_\_\_\_                      INITIAL \_\_\_\_    DATE \_\_\_\_

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ALL CLAIMS.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

I AUTHORIZE THE RELEASE OF PAYMENT FOR MEDICAL BENEFITS TO MY PHYSICIAN.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_