PATIENT INFORMATION

TODAY'S DATE:_____ **PREFERRED PHARMACY:**_____

AGE:_____

NAME:_____ BIRTHDATE:_____SEX: M F

HOME ADDRESS:_____
STREET APT# CITY STATE ZIP CODE

HOME PHONE:_____MOBILE PHONE_____

WORK PHONE:_____MARITAL STATUS: S M D W DP

EMPLOYER:_____OCCUPATION:_____

PRIMARY INSURANCE:

NAME:_____ BIRTHDATE:_____SEX: M F

HOME ADDRESS:_____
STREET APT# CITY STATE ZIP CODE

HOME PHONE:_____MOBILE PHONE_____

EMPLOYER:_____RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE:

NAME:_____ BIRTHDATE:_____SEX: M F

HOME ADDRESS:_____
STREET APT# CITY STATE ZIP CODE

HOME PHONE:_____MOBILE PHONE_____

EMPLOYER:_____RELATIONSHIP TO PATIENT:_____

GUARANTOR OR EMERGENCY CONTACT:

NAME:_____ BIRTHDATE:_____SEX: M F

HOME ADDRESS:_____
STREET APT# CITY STATE ZIP CODE

HOME PHONE:_____MOBILE PHONE_____

RELATIONSHIP TO PATIENT:_____

MEDICAL INFORMATION

PREVIOUS ILLNESS	HAVE YOU HAD?		
ASTHMA	NO	YES	WHEN_____
AIDS/HIV+	NO	YES	WHEN_____
BLEEDING DISORDER	NO	YES	WHEN_____
BLOOD TRANSFUSION	NO	YES	WHEN_____
CANCER	NO	YES	WHEN_____
CHRONIC LUNG DISEASE	NO	YES	WHEN_____
DIABETES	NO	YES	WHEN_____
GASTROINTESTINAL DISEASE	NO	YES	WHEN_____
HAY FEVER	NO	YES	WHEN_____
HEART DISEASE	NO	YES	WHEN_____
HEPATITIS	NO	YES	WHEN_____
HYPERTENSION	NO	YES	WHEN_____
KIDNEY DISEASE	NO	YES	WHEN_____
NEUROLOGICAL DISEASE	NO	YES	WHEN_____
PNEUMONIA	NO	YES	WHEN_____
STROKE	NO	YES	WHEN_____
ULCER	NO	YES	WHEN_____

ANY OTHER MAJOR MEDICAL PROBLEMS:

_____

_____

_____

HEIGHT:_____ WEIGHT:_____

SMOKER: NO YES ALCOHOL: NO YES

ARE YOU ALLERGIC TO:		
PENICILLIN	NO	YES
SULFA	NO	YES
ERYTHROMYCIN	NO	YES
CODEINE	NO	YES
ASPIRIN	NO	YES

OTHER:_____

_____

_____

CURRENT MEDICATIONS:

NAME: DOSAGE:

_____

_____

_____

_____

_____

_____

PREVIOUS SURGERY:

DATE: OPERATION:

_____

_____

_____

PREVIOUS HOSPITALIZATION:

DATE: REASON:

_____

_____

_____

RELEASE OF INFORMATION

The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain payment and to obtain reimbursement, this office may disclose portions of the patient's records including his/her medical records to any person or corporation, worker's compensation carriers, the Social Security Administration or the intermediaries.

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to this office of any insurance benefits otherwise payable to or on behalf of the undersigned for these services. It is understood by the undersigned that he/she is financially responsible for the charges incurred. If the insurance company has failed to pay within a third day period, payment in full is expected and you must collect from your insurance company.

_____ _____

SIGNATURE **TODAY'S DATE**

OPTIONAL:RELEASE FOR MEDICAL CARE IF MINOR: I hereby give David Stone MD or any doctor he designates, authorization to care for the medical needs of my child in my absence.

PARENT OR GUARDIAN:_____ **TODAY'S DATE:**_____

SIGNATURE