

Patient Demographic Sheet

Patient Name: _____ Date of Birth _____
 Address _____ City _____
 State _____ Zip Code _____ HM Phone # _____ WK# _____
 Cell # _____ e-mail Address _____
 Sex: M F Marital Status: M S D W Social Security # _____

HIPAA REQUIREMENTS

Release of Information:

- A - Appropriate Release of Info on File
- I - Informed Consent to Release Medical
- M- Provider has Limited Release Data
- N- No, Provider is Not Allowed to Release
- O- On File at Payer
- Y- Yes, Provider has Signed Release

Signature Source

- B-Signed Signature Authoriz. Block 12 & 13
- C-Signed HCFA-1500 Form on File
- M-Signed Signature Authoriz. Block 13 Only
- P-Signature by Provider, Patient not Present
- S-Signed Signature Authoriz. Block 12 Only

Circle Y=yes or N-No

Pregnant Y N

If Yes LMP _____

Home Bound Y N

Hospice Y N

Date of Injury _____ Work Related Yes No
 Referring Physician _____ Phone _____
 Family Physician _____ Phone _____
 Reason for Appointment _____
 Employer _____ Employer Phone _____
 Emergency Contact _____ Emergency Phone Number _____
 Guarantor Responsible for Bill _____ Phone Number _____
 Spouse Name _____ Spouse Employer _____

INSURANCE INFORMATION - PRIMARY

(Please Attach a Copy of the Front and Back of Patient Insurance Card (s).)

Cardholder's Name _____ Date of Birth _____
 Insurance Co. Name _____ Address _____
 Id /Certificate Number _____ Group Number _____
 Insurance Co Tele. Number _____ Relationship to Patient _____

INSURANCE INFORMATION - SECONDARY

(Please Attach a Copy of the Front and Back of Patient Insurance Card (s).)

Cardholder's Name _____ Date of Birth _____
 Insurance Co. Name _____ Address _____
 Id /Certificate Number _____ Group Number _____
 Insurance Co Tele. Number _____

I, the undersigned, am aware that I am responsible for the payment of any co-pays and/or deductibles that may apply under my medical insurance contract. It is my responsibility to check with my insurance company to be sure that the physician is in my insurance network. I assume personal responsibility for any amount that insurance does not pay and deems payable by myself. I also agree to pay all fees if I have no insurance coverage. It is my responsibility to have a referral at the time of service. If I do not have a referral, I will pay all fees.

I, the undersigned, have received the Practice's notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I authorize the release of any medical information necessary to process my claims, and payment of government benefits to the above mentioned office.

Patient or Authorized Signature: _____ Date _____

Name: _____ Date of Birth: _____ Age: _____ Sex: M / F

Allergies: (i.e. medications, dyes, foods...) (NONE _____)

List ALL your daily medications: (i.e. Prescriptions, vitamins, herbs, etc.) (NONE _____)

List ALL surgeries or hospitalizations (i.e. childbirth, heart attack, pneumonia, etc.) (NONE _____)

PLEASE CIRCLE IF YOU HAVE HAD OR DO HAVE: (ROS)

Heart stents (date) _____ Height _____

Lung problems (please list) _____

Heart problems (please list) _____ Weight _____

Cancer (of what) _____ Is your weight stable Y / N

Depression	Y / N	Infected teeth	Y / N	High thyroid	Y / N
Anxiety	Y / N	Non-filled teeth	Y / N	Low thyroid	Y / N
Bronchitis	Y / N	Bleeding gums	Y / N	Dizzy spells	Y / N
Pneumonia	Y / N	Sore gums	Y / N	Coughing up blood	Y / N
Ulcers	Y / N	Hepatitis	Y / N	Frequent/severe headache	Y / N
Abdominal pain	Y / N	Vision problems	Y / N	Frequent nose bleeds	Y / N
Kidney stones	Y / N	Hard of hearing	Y / N	Frequent vomiting	Y / N
Blood in your stool	Y / N	Weakness in legs	Y / N	Frequent nausea	Y / N
Chest pain	Y / N	Weakness in arms	Y / N	Vomiting of blood	Y / N
Paralysis in your legs	Y / N	Constipation	Y / N	Ringing in ears	Y / N
Paralysis in your arms	Y / N	Short of breath at rest	Y / N	Broken bones	Y / N
Blood transfusion	Y / N	Short of breath w mild exertion	Y / N	Stroke	Y / N
Numbness in your legs	Y / N	High cholesterol	Y / N	Easily tired	Y / N
Numbness in your arms	Y / N	Diabetes	Y / N	High blood pressure	Y / N

List any other medical illness: _____

What type of work do you do? _____ What shift do you work? _____

Do you drink? Y / N # _____ Cans/glass per day / week Beer Wine Liquor

Do you smoke? Y / N How many packs per day? _____ For how many years? _____

Have you smoked in the past? Y / N How many packs per day _____ For how many years? _____ Quit _____ yrs. ago

YOUR family history

Cancer: Yes / No
who _____

Heart attack: Yes / No
who _____

Stroke: Yes / No
who _____

Signature: _____ Date: _____