PATIENT INFORMATION/MEDICAL HISTORY

Name:_____ Date:_____ Age:_____

Address:_____
Street City State Zip Code

Phone: Home:_____ Work:_____Cell:_____

Date of Birth:_____ Marital Status:_____ SS#:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship:_____ Phone_____

E-Mail address: _____

How did you hear about us: _____

Health History

Medication (prescription and over the counter; vitamins, herbal medications)

_____
_____
_____

Allergies:_____

Surgeries/Dates:_____
_____

Have a History of?

__Heart Disease	__Mental Disease	__Neuro-muscular Disease
__Excessive Bleeding	__Auto-immune Disorders	__Diabetes
__High Blood Pressure	__Liver Disease	__Cold Sores/Fever Blisters
__Other		

_____

Are you? Pregnant_____ Nursing_____

Do you? Smoke_____ Drink Alcohol_____ Amount per day_____

The above information is true and accurate to the best of my knowledge.

_____ _____
Patient Signature Date