

Do you have an insurance plan? YES NO

If yes, insurance name, phone # & ID#: _____

Spouse or Guardian:

Name: _____

Address: _____

City, State, Zip Code: _____

E-Mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____

Address: _____

City, State, Zip Code: _____

Date of Birth: _____ SSN: _____

MEDICAL HISTORY

Do you have any general health problems? YES NO

If yes, please specify: _____

Are you currently under the care of a physician? YES NO

Reason: _____

Name of Physician and phone #: _____

Are you currently taking any drugs or medications? YES NO

If yes, please list: _____

To the best of your knowledge, are you or have you ever been afflicted with:

Asthma YES NO

Heart Ailment YES NO

Diabetes YES NO

High Blood Pressure YES NO

Hepatitis YES NO

Latex Allergy YES NO

Allergy to any Drugs YES NO

I certify that I have answered the above questions to the best of my knowledge.

Signature of Patient (or parent, if minor)

NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient:

(if signed by a personal representative of patient:)
