WELCOME to our Practice

CANCELATION NOTICE

Less than a 24-hour appt cancelation notice will result in a $50 New Patient Cancelation Fee; Follow-up appts are $25

About you

Today's Date: ____/____/____

Patient Name: _____
LAST FIRST MI

Prefer To Be Called: _____ ☐ Male ☐ Female

Birth date: ____/____/____ Age: ____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Referred By: _____

Employer: _____ How long? _____

Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Other

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How many? _____

Insurance information

Please give Insurance cards to secretary for copying

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #:_____

Claim / ID #: _____

Group #: _____

Insured's Name: _____

Insured's SS#: _____

Relation: _____ DOB: ____/____/____

Insured's Employer: _____

2nd Insurance: _____

Member ID#: _____

Drivers License #:_____

State Issued:_____

Expires:_____

Reason for Visit

The reason for this visit is a result of (Please circle): work, sports, auto, trauma, or chronic

(Explain what happened): _____

When did condition begin? ____/____/____ Is this condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Is this condition interfering with your (Please circle): work, sleep, or daily routine

If so, please explain: _____

Have you ever had this or similar conditions in the past? ☐ Yes ☐ No

If so, please explain:_____

Have you ever been treated by a Medical Physician for this condition? ☐ Yes ☐ No

If so, where? _____

In event of emergency

Who should we contact? _____ Relation _____ Phone # _____

Patient:_____ _____ DOB:_____

Health History

What medications, supplements and vitamins are you currently taking?_____

_____

What medications are you allergic to? _____

_____

Are you on a special diet? ☐ No ☐ Yes / Since:____/____/_____ Please describe:_____

Do you smoke? ☐ No ☐ Yes / How Much?_____ How long?_____ If you quit, at what age?_____

Do you drink alcohol? ☐ No ☐ Yes / How Much?_____ Do you use caffeine? ☐ No ☐ Yes / How Much?_____

Do you use any street drugs? ☐ No ☐ Yes / What kind? _____ How frequently?_____

What is your occupation? _____

Please check if your occupation exposes you to the following: ☐ Stress ☐ Hazardous substances ☐ Heavy lifting ☐ Other_____

Symptoms ~ check ("√" for current symptoms & "×" for symptoms you've had in the past):

GENERAL
- ☐ Acne
- ☐ Chills
- ☐ Depression
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Sweats

MUSCLE JOINT BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger/thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Reflux/ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular heartbeat
- ☐ Rapid heartbeat
- ☐ Poor circulation
- ☐ Swelling of the ankles
- ☐ Varicose veins

EYE/EAR/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – flashes
- ☐ Vision – halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN ONLY
- ☐ Breast lump
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Mother or Sister w/Breast Cancer
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Pre-menstrual Syndrome
- ☐ Vaginal discharge

Date of last menstrual period _____

Date of last pap smear:_____

Last mammogram? Date:_____

Are you pregnant? ☐ Yes ☐ No

Number of children_____

Are you taking birth control?

☐ Yes ☐ No

Patient:_____ _____DOB:_____

Conditions ~ Do you have or ever had any of the following diseases or conditions?

Y N AIDS	Y N Chemical dependency	Y N Hernia	Y N Prostate Problems
Y N Alcoholism	Y N Chemotherapy	Y N Herpes	Y N Psychiatric care
Y N Anemia	Y N Chicken Pox	Y N High Cholesterol	Y N Rheumatic Fever
Y N Anorexia	Y N Colitis	Y N HIV Positive	Y N Scarlet Fever
Y N Appendicitis	Y N Congenital Heart Disease	Y N Kidney disease	Y N Seizures
Y N Arthritis	Y N Diabetes	Y N Liver Disease	Y N Shingles
Y N Artificial Bones/Joints	Y N Emphysema	Y N Measles	Y N Stroke
Y N Artificial Valves	Y N Epilepsy	Y N Migraine Headaches	Y N Suicide attempt
Y N Asthma	Y N Glaucoma	Y N Miscarriage	Y N Thyroid problems
Y N Bleeding Disorders	Y N Goiter	Y N Mononucleosis	Y N Tonsillitis
Y N Breast Lump	Y N Gonorrhea	Y N Multiple Sclerosis	Y N Tuberculosis
Y N Bronchitis	Y N Gout	Y N Mumps	Y N Typhoid Fever
Y N Bulimia	Y N Heart Disease	Y N Pacemaker	Y N Ulcers
Y N Cancer	Y N Heart Murmur	Y N Pneumonia	Y N Vaginal Infections
Y N Cataracts	Y N Hepatitis	Y N Polio	Y N Venereal Disease

***Please list any other serious **medical condition**(s) you have or ever had: _____

_____

Hospitalization

Year	Hospital	Reason for hospitalization and outcome

Serious Illness/Injury

Date	Instance	Outcome

Have you ever had a blood Transfusion? ☐ Yes ☐ No

If yes give approximate dates: _____

Patient:_____ _____DOB:_____

Family History

Relation	Age	State of Health	Age of Death	Disease/disorders	Check if your blood relatives had any of the following	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. It is the patient's responsibility to schedule any necessary follow-up appointments and to assure that the results of any and all testing is conveyed to the patient or guardian. This may require an appointment in the office.
- MEDICARE PATIENTS: We do not accept Medicare Insurance and see beneficiaries under 'Private Contracting'. I agree not submit claims to Medicare for reimbursement.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. If litigation becomes necessary to recover payment, the prevailing party will be entitled to attorney's fees. Additionally, you will be responsible for late fees added at 1.5% per month.
- Unpaid balances over 30 days of the date of service will incur a 2% late fee per month for services and product sales.
- I authorize www.DRAdrianMD.com and its affiliates to receive and fulfill orders placed by me for medications and to access medical records to verify prescriptions.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____/_____/_____

□ Adult Patient □ Parent or Guardian □ Spouse