

Patient-Minor		Male	Female	Do you reside with guarantor?		Yes	No
Full Name		DOB	Age	Social Security No.			
Mailing Address			Email			Home Phone	
LEGAL PARENT OR	DOB:	Male	Female	Social Security No.			Years in area
Mailing Address			Driver Lic #	Relationship to Patient			
Street Address			Years at this address	Home Phone			
Previous Address If less than 2 yrs at above address				Email:		Years at Previous Address	
Employer & Emp Address					Work Phone		
Length of Employment	Yrs	Position		Name of Supervisor			
Do you own your own home? Yes No		If no, Name & Phone No of Landlord					
Do you have	Yes	Have you ever had a bill Sent to a collection agency	Yes No	If yes, is it now paid in full?	Yes No	Have you ever Declared bankruptcy?	Yes Date: No
						Have you every had Property repossessed?	Yes No
OTHER PARENT OR GUARDIAN		DOB:	Male	Female	Social Security No.		
Full Name					Driver Lic #		
Mailing Address					Do you reside with guarantor? Yes No		
Employer & Emp Address					Work Phone		
Medical Insurance Information		We request that deductibles and co-payments be paid at the time of service.				Type of Policy: Group Private HMO OR Health Plan	
Primary Insurance Name & Address							
Group No: Member No			Deductible:		CoPay:		
Are any of the following required?		Referral from primary care physician		Prior authorization		We do not file secondary insurance. We need the information on file to respond to inquiries.	
Secondary Insurance					Name of Policyholder		
Group No: Member No			Deductible:		CoPay:		
Are any of the following required?		Referral from primary care physician		Prior authorization		Type of Policy: Group Private HMO OR Health Plan	
Referring Physician					PCP		
Emergency Name, Address & Phone #					Relationship to Patient		
<p>Regulation Z of the Federal Truth in Lending Act requires us to state that we operate on a payment at time of visit basis When granted, credit is extended to approved applications on the following terms only: Each patient will have the option to make payment in full within 30 days or make monthly installments in the amount determined by the scheduled outlined in our Office Policy (approximately 10% of the unpaid balance). All accounts are subject to a finance charge of ten percent (10%) a year or 0.8333 percent per month on any balances outstanding for 90 days or more.</p> <p>I agree to the above terms and to pay finance charge of 10% per year on balances outstanding 90 days or more. I understand and agree that if it becomes necessary to turn this matter over for collection, the prevailing party shall be entitled to recover reasonable costs including attorney fees together with interest as provided by law on all amounts found due for professional services.</p> <p>I authorize the release of any medical information necessary to process any insurance claim for professional services received.</p> <p>I have read the Office Policy and agree to the provisions contained therein.</p>							
Date:		Signature					
I do not wish credit. I will pay charges in full the same day I see the Doctor.							
Date:		Signature					
<p>Consent to Treatment: I consent to treatment as necessary or desirable for the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operation and conduct of laboratory, x-ray or other studies that may be used by the attending Medical Doctor or qualified designate. It is my understanding that the need for each test, medication and surgical procedure will be fully explained.</p>							

Medical History: Have you had any of the problems listed below?

Please check the boxes next to the illnesses you have had	Date Discovered	Currently Active?	Current Medication for this problem
Diabetes		Yes No	
High Blood Pressure		Yes No	
Heart Disease		Yes No	
Tuberculosis		Yes No	
Loss of consciousness or seizure		Yes No	
Stroke		Yes No	
Frequent headaches		Yes No	
Kidney disease		Yes No	
Asthma		Yes No	
Hay fever		Yes No	
Eczema		Yes No	
Hives		Yes No	
Arthritis		Yes No	
Emphysema		Yes No	
Bleeding disorder		Yes No	
Bowel problems		Yes No	
Skin disorder		Yes No	
Cancer		Yes No	
Bladder or kidney infection		Yes No	
Anemia		Yes No	
Stomach ulcer		Yes No	
Frequent dizziness		Yes No	
Liver disease		Yes No	
Venereal disease		Yes No	
Other:		Yes No	

Please list all medications not listed elsewhere on this page including birth control pills, vitamins, laxatives, cold remedies, herbals, lotions and salves

Family History: Has anyone in your immediate family ever had the following:

Allergies	Mother	Father	Sibling	Grandparent
Eczema				
Psoriasis				
Hay Fever				
Asthma				
Diabetes				
Melanoma				
Other Skin Disease				

List all **allergies** including medications, chemicals, anesthetics, herbals and foods.

List the date and diagnosis for all hospitalizations

What brings you to see the Doctor today?
