

Personal Information

Please complete this form. All information is confidential. Thank You.

Today's Date: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 First & Last Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
 Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Preferred Language: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Telephone #: Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
 Preferred Language: \_\_\_\_\_  
 Preferred method of contact? \_\_\_\_\_ Would you like to be added to our mailing list? \_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Spouse/Significant Other's Name \_\_\_\_\_  
 Spouse's Contact Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_  
 Emergency Contact Name: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 Primary Care Physician: Name: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_  
 Insurance Information Company \_\_\_\_\_  
 Member # \_\_\_\_\_ Group # \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Insured DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Insured Home Number (\_\_\_\_) \_\_\_\_\_  
 Secondary Insurance Information Company \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Insured DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ Insured Home Number (\_\_\_\_) \_\_\_\_\_  
 Responsible party (if patient is a minor):  
 Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Preferred Pharmacy: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 How did you hear about our office? \_\_\_\_\_  
 Whom may we thank for the referral? \_\_\_\_\_  
 Reason for consultation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

History and Physical

Height:\_\_\_\_ Weight:\_\_\_\_ Normal Weight:\_\_\_\_

Do you have any allergies to medication? (Yes/No) \_\_\_\_

Please List:\_\_\_\_\_

Reaction:\_\_\_\_\_

Please list ALL medications and herbal supplements (including vitamins, herbs, sleep aids, etc.)\_\_\_\_\_

\_\_\_\_\_

Do you take Aspirin or Ibuprofen on a regular basis? \_\_Yes\_\_ No

Do you smoke or use tobacco products? \_\_\_\_ How many per day?\_\_\_\_ (cigarettes/packs) Number of years?\_\_\_\_

If you have stopped smoking when did you quit?\_\_\_\_ mo./years Date you quit:\_\_\_\_/\_\_\_\_

Tobacco use other than cigarettes?\_\_\_\_\_

Do you consume alcohol?\_\_\_\_ How many drinks containing alcohol per week?\_\_\_\_

Do you use recreational drugs?\_\_\_\_ Have you ever been treated for drug or alcohol dependency?\_\_\_\_

Are you on a diet pill or diet program now?\_\_\_\_ Have you been in the last 3 years?\_\_\_\_

Do you exercise?\_\_\_\_ How often?\_\_\_\_\_

Medical History

Do you have or have you ever been treated for: (Y/N)

- |                               |                             |                               |
|-------------------------------|-----------------------------|-------------------------------|
| Malignant hyperthermia?____   | Thyroid problem? ____       | Mental illness? ____          |
| Autoimmune disorder? ____     | Bulimia or anorexia? ____   | Drug Dependency? ____         |
| Chronic illness? ____         | Hepatitis/Jaundice? ____    | Depression? ____              |
| Heart Disease? ____           | Ulcers? ____                | Lung Disease? ____            |
| Heart attack? ____            | Epilepsy/Seizures? ____     | Cancer? ____                  |
| Stroke? ____                  | Cold Sores? ____            | Serious Accident? ____        |
| High blood pressure? ____     | Mitral Valve Prolapse? ____ | Sleep apnea? ____             |
| Blood disorder? ____          | Kidney problems? ____       | CPAP machine? ____            |
| Blood clotting disorder? ____ | Shortness of breath? ____   | Latex allergies? ____         |
| Anemia? ____                  | Asthma? ____                | Environmental allergies? ____ |
| Diabetes? ____                | Emphysema? ____             |                               |
| Other? _____                  |                             |                               |

If you answered yes to any of the above, please explain:\_\_\_\_\_

\_\_\_\_\_

Have you ever received a blood transfusion?\_\_\_\_ Date:\_\_\_\_\_

Have you ever been diagnosed with:

Tuberculosis?\_\_\_\_ Date:\_\_\_\_\_ HIV?\_\_\_\_ Date:\_\_\_\_\_ Hepatitis?\_\_\_\_ Date:\_\_\_\_\_

Female Patients Only:

Are you pregnant?\_\_\_\_ Are you breastfeeding?\_\_\_\_

Have you ever been treated for:

Abnormal bleeding?\_\_\_\_ How long ago?\_\_\_\_ Anemia?\_\_\_\_ How long ago?\_\_\_\_

Do you use any birth control?\_\_\_\_ What type?\_\_\_\_\_

Do you have children?\_\_\_\_ Number of pregnancies?\_\_\_\_



Surgical History

PLEASE LIST ALL PREVIOUS SURGERIES (including cosmetic and dental procedures):

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

Anesthesia problems?(includenausea/vomiting, slow to wake up or hightemperature) \_\_\_\_\_

Past hospitalizations \_\_\_\_\_

Please initial the following:

- The above information is current and correct to the best of my knowledge. \_\_\_\_\_
- I authorize the release of my medical records to insurance companies and authorize the release of any medical information necessary to process my insurance claim. \_\_\_\_\_
- I give my permission to be treated by Dr. Jeremy White and his staff now and in the future and assign all benefits directly to Dr. White. I assume full responsibility for my balance regardless of the status of my insurance claim. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician(s) or supplier of rendered services. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of charges for services rendered. \_\_\_\_\_
- If computer imaging is used in my evaluation, I understand that the alteration is purely for the purpose of illustration and discussion and in no way constitutes an expressed or implied warranty as to my final results and appearance. \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

