PATIENT INFORMATION
(PLEASE PRINT)

NAME ______________________ DATE ______________

ADDRESS ______________________ CITY ______________ ZIP CODE __________

HOME PHONE ______________ BUSINESS PHONE ______________ CELL PHONE ______________

DATE OF BIRTH __________ AGE ______ SOCIAL SEC. NO. ______________ MARITAL STATUS S M W D SEP.

REFERRED BY ______________________ PERSONAL PHYSICIAN ______________

PATIENT'S EMPLOYER ______________________ POSITION ______________

BUSINESS ADDRESS ______________________________________

SPOUSE'S NAME ______________ SPOUSE'S SOCIAL SEC. NO. ______________ SPOUSE'S EMPLOYER ______________ SPOUSE'S WK PHONE ______________

PERSON RESPONSIBLE FOR BILL

NAME ______________________ RELATIONSHIP ______________

ADDRESS (IF OTHER THAN ABOVE) ______________________ HOME PHONE ______________

CELL PHONE ______________

EMPLOYER ______________________ POSITION ______________

BUSINESS ADDRESS ______________________ BUSINESS PHONE ______________

PRIMARY INSURANCE INFORMATION

Subscriber Last Name ______________________ First ______________ M ______

Subscriber Social Security Number ______________ Subscriber Date of Birth ____ / ____ / ____

Subscriber Contract Number ______________________ Subscriber Group Number ______________

Subscriber Plan ______________________ Subscriber Type ______________

Patient is related to the Primary Subscriber _____ Self _____ Spouse _____ Child Effective Date ____ / ____ / ____

SECONDARY INSURANCE INFORMATION

Subscriber Last Name ______________________ First ______________ M ______

Subscriber Social Security Number ______________ Subscriber Date of Birth ____ / ____ / ____

Subscriber Contract Number ______________________ Subscriber Group Number ______________

Subscriber Plan ______________________ Subscriber Type ______________

Patient is related to the Primary Subscriber _____ Self _____ Spouse _____ Child Effective Date ____ / ____ / ____

If student covered under parents insurance

Are you _____ Employed Full Time _____ Employed Part Time _____ Not Employed _____ Serving Active Duty

Are you _____ Full Time Student _____ Part Time Student _____ Not a Student

How were you referred to our office? Doctor _____ Yellow Pages _____ Mailer _____ Friend _____ Name ______________

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY

NAME ______________________ RELATIONSHIP ______________

ADDRESS ______________________ HOME PHONE ______________

EMPLOYER ______________ POSITION ______________ BUSINESS PHONE ______________

(NEXT PAGE)

IN ORDER TO CONTROL OUR BILLING COSTS AND REDUCE FEE INCREASES, WE REQUEST THAT OFFICE VISITS BE PAID AT THE TIME OF SERVICE.

AUTHORIZATIONS

BENEFITS TO PHYSICIAN:

☐ Yes ☐ No I hereby authorize payments directly to the physician of the surgical and/or medical benefits.

☐ Yes ☐ No I also understand I am responsible for any portion of my bill not covered by my insurance company.

RELEASE OF INFORMATION:(WE CANNOT FILE YOUR CLAIM WITHOUT THIS SIGNED RELEASE)

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES

☐ Yes ☐ No The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

☐ Yes ☐ No I have been provided with a **PATIENT INFORMATION PRIVACY NOTICE** that gives a more complete description of information uses and disclosures.

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THAT THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

Signed ______________________________ Date ______________________________ 20______

Health Analysis

No. ____________ Date ____________________

Patient ______________________________________ Home Phone (___) ____________

Address ______________________ City ____________ State ______ Zip ____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Age __________ Occupation ____

1. Do you need glasses to read? ☐ YES ☐ NO
2. Do you need glasses to see things at a distance? ☐ YES ☐ NO
3. Has your eyesight blacked out completely? ☐ YES ☐ NO
4. Do your eyes continually blink or water? ☐ YES ☐ NO
5. Do you often have bad pains in your eyes? ☐ YES ☐ NO
6. Are your eyes often red or inflamed? ☐ YES ☐ NO
7. Are you hard of hearing? ☐ YES ☐ NO
8. Have you ever had a fluid leaking from your ear? ☐ YES ☐ NO
9. Do you have constant noises in your ears? ☐ YES ☐ NO

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10. Do you have to clear your throat constantly? ☐ YES ☐ NO
11. Do you often feel a choking lump in your throat? ☐ YES ☐ NO
12. Are you often troubled with bad spells of sneezing? ☐ YES ☐ NO
13. Is your nose continually stuffed up? ☐ YES ☐ NO
14. Do you suffer from a constantly running nose? ☐ YES ☐ NO
15. Have you at times had bad nose bleeds? ☐ YES ☐ NO
16. Do you often catch severe colds? ☐ YES ☐ NO
17. Do you frequently suffer from heavy chest colds? ☐ YES ☐ NO
18. When you catch a cold, do you always have to go to bed? ☐ YES ☐ NO
19. Do frequent colds keep you miserable all winter? ☐ YES ☐ NO
20. Do you get hay fever? ☐ YES ☐ NO
21. Do you suffer from asthma? ☐ YES ☐ NO
22. Are you troubled by constant coughing? ☐ YES ☐ NO
23. Have you ever coughed up blood? ☐ YES ☐ NO
24. Do you wake up drenched with sweat during the middle of the night? ☐ YES ☐ NO
25. Have you ever had a chronic chest condition? ☐ YES ☐ NO
26. Have you ever had T.B. (tuberculosis)? ☐ YES ☐ NO
27. Did you ever live with anyone who had T.B.? ☐ YES ☐ NO

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28. Has a doctor ever said your blood pressure was too high? ☐ YES ☐ NO
29. Has a doctor ever said your blood pressure was too low? ☐ YES ☐ NO
30. Do you have pains in the heart or chest? ☐ YES ☐ NO
31. Are you often bothered by thumping of the heart? ☐ YES ☐ NO
32. Does your heart often race like mad? ☐ YES ☐ NO
33. Do you often have difficulty in breathing? ☐ YES ☐ NO
34. Do you get out of breath before anyone else? ☐ YES ☐ NO
35. Do you sometimes get out of breath just sitting still? ☐ YES ☐ NO
36. Are your ankles often badly swollen? ☐ YES ☐ NO
37. Do cold hands or feet trouble you, even in hot weather? ☐ YES ☐ NO
38. Do you suffer from frequent cramps in your legs? ☐ YES ☐ NO
39. Has a doctor ever said you had heart trouble? ☐ YES ☐ NO
40. Does heart trouble run in your family? ☐ YES ☐ NO

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41. Have you lost more than half your teeth? ☐ YES ☐ NO
42. Are you troubled by bleeding gums? ☐ YES ☐ NO

43. Have you often had severe toothaches? ☐ YES ☐ NO
44. Is your tongue usually badly coated? ☐ YES ☐ NO
45. Is your appetite always poor? ☐ YES ☐ NO
46. Do you usually eat sweets or other foods between meals? ☐ YES ☐ NO
47. Do you always gulp your food hurriedly? ☐ YES ☐ NO
48. Do you often suffer from an upset stomach? ☐ YES ☐ NO
49. Do you usually feel bloated after eating? ☐ YES ☐ NO
50. Do you usually belch a lot after eating? ☐ YES ☐ NO
51. Are you often sick at your stomach? ☐ YES ☐ NO
52. Do you suffer from indigestion? ☐ YES ☐ NO
53. Do severe pains in the stomach often cause you to double over? ☐ YES ☐ NO
54. Do you suffer from constant stomach trouble? ☐ YES ☐ NO
55. Does stomach trouble run in your family? ☐ YES ☐ NO
56. Has a doctor ever said you had stomach ulcers? ☐ YES ☐ NO
57. Do you suffer from frequent loose bowel movements? ☐ YES ☐ NO
58. Have you ever had severe bloody diarrhea? ☐ YES ☐ NO
59. Were you ever troubled with intestinal worms? ☐ YES ☐ NO
60. Do you constantly suffer from bad constipation? ☐ YES ☐ NO
61. Have you ever had piles (rectal hemorrhoids)? ☐ YES ☐ NO
62. Have you ever had jaundice (yellow eyes and skin)? ☐ YES ☐ NO
63. Have you ever had serious liver or gall bladder trouble? ☐ YES ☐ NO

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64. Are your joints often painfully swollen? ☐ YES ☐ NO
65. Do your muscles and joints constantly feel stiff? ☐ YES ☐ NO
66. Do you usually have severe pains in the arms or legs? ☐ YES ☐ NO
67. Are you crippled with severe arthritis? ☐ YES ☐ NO
68. Does arthritis run in your family? ☐ YES ☐ NO
69. Do weak or painful feet make your life miserable? ☐ YES ☐ NO
70. Do pains in the back make it hard for you to keep up with your work? ☐ YES ☐ NO
71. Are you troubled with a serious bodily disability or deformity? ☐ YES ☐ NO

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72. Do you have sensitive skin? ☐ YES ☐ NO
73. Does it take a long time for a cut to heal? ☐ YES ☐ NO
74. Does your face often get badly flushed? ☐ YES ☐ NO
75. Do you sweat a great deal, even in cold weather? ☐ YES ☐ NO
76. Are you often bothered by severe itching? ☐ YES ☐ NO
77. Does your skin often break out in a rash? ☐ YES ☐ NO
78. Are you often troubled with boils? ☐ YES ☐ NO

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79. Do you suffer from frequent severe headaches? ☐ YES ☐ NO
80. Does pressure or pain in the head often make life miserable? ☐ YES ☐ NO
81. Are headaches common in your family? ☐ YES ☐ NO
82. Do you have hot or cold spells? ☐ YES ☐ NO
83. Do you often have spells of severe dizziness? ☐ YES ☐ NO
84. Do you frequently feel faint? ☐ YES ☐ NO
85. Have you fainted more than twice in your life? ☐ YES ☐ NO
86. Do you have constant numbness or tingling in any part of your body? ☐ YES ☐ NO
87. Was any part of your body ever paralyzed? ☐ YES ☐ NO
88. Were you ever knocked unconscious? ☐ YES ☐ NO
89. Have you at times had a twitching of the head, face or shoulders? ☐ YES ☐ NO
90. Did you ever have a severe seizure or convulsion (epilepsy)? ☐ YES ☐ NO
91. Has anyone in your family ever had a seizure or convulsion (epilepsy)? ☐ YES ☐ NO
92. Do you bite your nails? ☐ YES ☐ NO
93. Are you troubled by stuttering or stammering? ☐ YES ☐ NO
94. Are you a sleepwalker? ☐ YES ☐ NO
95. Are you a bed wetter? ☐ YES ☐ NO
96. Were you a bed wetter between the ages of 8 to 14? ☐ YES ☐ NO

WOMEN ONLY... ARE YOU PREGNANT? ☐ YES ☐ NO

97w.	Have your menstrual periods usually been painful?	☐ YES	☐ NO
98w.	Have you often felt weak or sick with your periods?	☐ YES	☐ NO
99w.	Have you often had to lie down when your periods came on?	☐ YES	☐ NO
100w.	Have you usually been tense or jumpy with your periods?	☐ YES	☐ NO
101w.	Have you ever had severe hot flashes or sweats?	☐ YES	☐ NO
102w.	Have you often been troubled with a vaginal discharge?	☐ YES	☐ NO

MEN ONLY

97m.	Have you ever had anything wrong with your genitals?	☐ YES	☐ NO
98m.	Are your genitals often painful or sore?	☐ YES	☐ NO
99m.	Have you ever had treatment for your genitals?	☐ YES	☐ NO
100m.	Has a doctor ever said you had a hernia (rupture)?	☐ YES	☐ NO
101m.	Have you ever passed blood while urinating?	☐ YES	☐ NO
102m.	Do you have trouble starting your stream when urinating?	☐ YES	☐ NO

103.	Do you have to get up every night and urinate?	☐ YES	☐ NO
104.	During the day, do you usually have to urinate frequently?	☐ YES	☐ NO
105.	Do you often have severe burning when you urinate?	☐ YES	☐ NO
106.	Do you sometimes lose control of your bladder?	☐ YES	☐ NO
107.	Has a doctor ever said you had kidney or bladder disease?	☐ YES	☐ NO
108.	Are you often exhausted or fatigued?	☐ YES	☐ NO
109.	Does working tire you out completely?	☐ YES	☐ NO
110.	Do you usually get up tired or exhausted in the morning?	☐ YES	☐ NO
111.	Does every little effort wear you out?	☐ YES	☐ NO
112.	Are you constantly too tired and exhausted to even eat?	☐ YES	☐ NO
113.	Do you suffer from severe nervous exhaustion?	☐ YES	☐ NO
114.	Does nervous exhaustion run in your family?	☐ YES	☐ NO
115.	Are you frequently ill?	☐ YES	☐ NO
116.	Are you frequently confined to bed by illness?	☐ YES	☐ NO
117.	Are you always in poor health?	☐ YES	☐ NO
118.	Are you considered a sickly person?	☐ YES	☐ NO
119.	Do you come from a sickly family?	☐ YES	☐ NO
120.	Do severe pains and aches make it impossible to work?	☐ YES	☐ NO
121.	Do you wear yourself out worrying about work?	☐ YES	☐ NO
122.	Are you always ill and unhappy?	☐ YES	☐ NO
123.	Are you constantly made miserable by poor health?	☐ YES	☐ NO
124.	Did you ever have scarlet fever?	☐ YES	☐ NO
125.	As a child, did you have rheumatic fever, growing pains, or twitching limbs?	☐ YES	☐ NO
126.	Did you ever have malaria?	☐ YES	☐ NO
127.	Were you ever treated for severe anemia?	☐ YES	☐ NO
128.	Were you ever treated for venereal disease?	☐ YES	☐ NO
129.	Do you have diabetes?	☐ YES	☐ NO
130.	Did a doctor ever say you had a goiter in your neck?	☐ YES	☐ NO
131.	Did a doctor ever treat you for a tumor or cancer?	☐ YES	☐ NO
132.	Do you suffer from any chronic disease?	☐ YES	☐ NO
133.	Are you definitely underweight?	☐ YES	☐ NO
134.	Are you definitely overweight?	☐ YES	☐ NO
135.	Did a doctor ever say you had varicose veins (swollen veins) in your legs?	☐ YES	☐ NO
136.	Did you ever have a serious operation?	☐ YES	☐ NO
137.	Did you ever have a serious injury?	☐ YES	☐ NO
138.	Do you often have small accidents or injuries?	☐ YES	☐ NO
139.	Do you usually have difficulty falling or staying asleep?	☐ YES	☐ NO
140.	Do you find it impossible to take a regular rest period each day?	☐ YES	☐ NO
141.	Do you find it difficult to exercise daily?	☐ YES	☐ NO

142. Do you smoke more than 20 cigarettes a day? ☐ **YES** ☐ **NO**
143. Do you drink more than 6 cups of coffee or tea a day? ☐ **YES** ☐ **NO**
144. Do you usually consume 2 or more alcoholic drinks a day? ☐ **YES** ☐ **NO**
145. Do you sweat or tremble a lot during examinations or questioning? ☐ **YES** ☐ **NO**
146. Do you get nervous and shaky when approached by a superior? ☐ **YES** ☐ **NO**
147. Does your work fall to pieces when a boss or superior is watching you? ☐ **YES** ☐ **NO**
148. Does your thinking get mixed up when you have to do things quickly? ☐ **YES** ☐ **NO**
149. Must you do things slowly to do them without mistakes? ☐ **YES** ☐ **NO**
150. Do you always get directions and orders wrong? ☐ **YES** ☐ **NO**
151. Are you anxious around unfamiliar people or places? ☐ **YES** ☐ **NO**
152. Are you scared to be alone when there are no friends around you? ☐ **YES** ☐ **NO**
153. Is it difficult to make up your mind? ☐ **YES** ☐ **NO**
154. Do you always wish you had someone at your side to advise you? ☐ **YES** ☐ **NO**
155. Are you considered a clumsy person? ☐ **YES** ☐ **NO**
156. Does it bother you to eat anywhere except your home? ☐ **YES** ☐ **NO**

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157. Do you feel alone and sad at a party? ☐ **YES** ☐ **NO**
158. Do you usually feel unhappy and depressed? ☐ **YES** ☐ **NO**
159. Do you often cry? ☐ **YES** ☐ **NO**
160. Are you always miserable and blue? ☐ **YES** ☐ **NO**
161. Does life look entirely hopeless? ☐ **YES** ☐ **NO**
162. Do you often wish you were dead and away from it all? ☐ **YES** ☐ **NO**

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163. Does worrying continually get you down? ☐ **YES** ☐ **NO**
164. Does worrying run in your family? ☐ **YES** ☐ **NO**
165. Does every little thing get on your nerves and wear you out? ☐ **YES** ☐ **NO**
166. Are you considered a nervous person? ☐ **YES** ☐ **NO**
167. Does nervousness run in your family? ☐ **YES** ☐ **NO**
168. Did you ever have a nervous breakdown? ☐ **YES** ☐ **NO**
169. Did anyone in your family ever have a nervous breakdown? ☐ **YES** ☐ **NO**
170. Were you ever a patient in a mental hospital? ☐ **YES** ☐ **NO**
171. Was anyone in your family ever in a mental hospital? ☐ **YES** ☐ **NO**

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172. Are you extremely shy or sensitive? ☐ **YES** ☐ **NO**
173. Do you have a shy or sensitive family? ☐ **YES** ☐ **NO**
174. Are your feelings easily hurt? ☐ **YES** ☐ **NO**
175. Does criticism always hurt you? ☐ **YES** ☐ **NO**
176. Are you considered a touchy person? ☐ **YES** ☐ **NO**
177. Do people usually misunderstand you? ☐ **YES** ☐ **NO**

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178. Is your guard up, even around your friends? ☐ **YES** ☐ **NO**
179. Do you always do things on sudden impulse? ☐ **YES** ☐ **NO**
180. Are you easily upset or irritated? ☐ **YES** ☐ **NO**
181. Do you go to pieces if you don't constantly control yourself? ☐ **YES** ☐ **NO**
182. Do little annoyances get on your nerves and get you angry? ☐ **YES** ☐ **NO**
183. Does it make you angry to have anyone tell you what to do? ☐ **YES** ☐ **NO**
184. Do people often annoy and irritate you? ☐ **YES** ☐ **NO**
185. Do you often flare up in anger if you can't have what you want right away? ☐ **YES** ☐ **NO**
186. Do you often get in a violent rage? ☐ **YES** ☐ **NO**

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187. Do you often shake or tremble? ☐ **YES** ☐ **NO**
188. Are you constantly keyed up or jittery? ☐ **YES** ☐ **NO**
189. Do sudden noises make you jump or shake? ☐ **YES** ☐ **NO**
190. Do you tremble or feel weak when someone shouts at you? ☐ **YES** ☐ **NO**
191. Do you become scared at sudden movements or noises at night? ☐ **YES** ☐ **NO**
192. Are you awakened out of your sleep by frightening dreams? ☐ **YES** ☐ **NO**
193. Do frightening thoughts keep coming back in your mind? ☐ **YES** ☐ **NO**
194. Do you often become frightened for no apparent reason? ☐ **YES** ☐ **NO**
195. Do you often break out in a cold sweat? ☐ **YES** ☐ **NO**

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