Patient Information

Patient's Name: (Last)_____ (First)_____ (MI)_____

Date of birth: _____ Sex: _____

Driver's License #: _____ State: _____

Address: Street_____

City: _____ State: _____ Zip: _____

Marital Status: _____

Phone: _____ (circle one) Cell Work Home

Email Address: _____

I agree to receiving appointment reminders. (Circle one) Yes No

Patient employed by: _____ Phone: _____

In case of an emergency, who should we notify? _____

Relationship to patient: _____ Phone: _____

Primary Pharmacy Used: _____ Location: _____

Primary Insurance

Company: _____ Policy Holder: _____

Date of birth: _____ Relationship to Patient: _____

ID #: _____ Group #: _____

Height: ____ft____in **Wt**.:_____lbs **Reason for exam**:_____

Past Medical History:

High Blood Pressure	___	DVT	___	Heart Trouble	___	HIV	___
High Cholesterol	___	Tuberculosis	___	Arthritis	___	Hepatitis	___
Kidney Disease	___	Nervous Dis	___	Gastro Dis	___	Osteoporosis	___
Thyroid Problems	___	Bleeding Dis	___	Stroke	___	Cancer	
Drug Abuse	___	Lung Disease	___	Diabetes	___	If yes, what?	
Joint Replacement	___	Asthma	___	Pneumonia	___	_____	

Other:_____

Surgical History:_____
_____

Family Medical History:

High Blood Pressure	___	DVT	___	Heart Trouble	___	HIV	___
High Cholesterol	___	Tuberculosis	___	Arthritis	___	Hepatitis	___
Kidney Disease	___	Nervous Dis	___	Gastro Dis	___	Osteoporosis	___
Thyroid Problems	___	Bleeding Dis	___	Stroke	___	Cancer	___
Drug Abuse	___	Lung Disease	___	Diabetes	___	If yes, what?	
Joint Replacement	___	Asthma	___	Pneumonia	___	_____	

Other:_____

Social History:

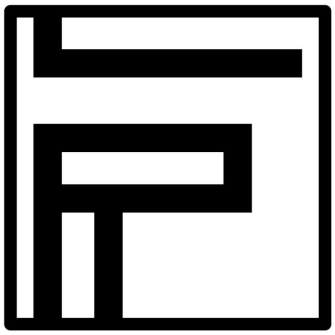
Occupation:_____ Marital Status:_____
Children:_____ Do you want to continue family planning? _____
Tobacco use:(circle one) Never Past Present
If so, how much and how often?_____
Alcohol use:(circle one) Never Past Present
If so, how much and how often?_____
Drug use: (circle one) Never Past Present
If so, how much and how often?_____

Any active complications:

General symptoms:_____
Heart:_____ Lung:_____Psyche:_____
Abdomen:_____ Endocrine:_____ Muscle/Bone/Joints:_____
Blood/Lymph:_____ OB/Genital:_____ Urinary:_____
Skin and/or Breasts:_____ Nervous:_____

Allergies:_____

Current Medications:_____
_____



Informed Consent of Treatment and Financial Policy

I, _____(print), hereby volunteer consent the rendering of care such as, physical exam, surgical, and medical treatment by providers or their assigned designees. I understand my previous medical and physical history that has been disclosed is true and accurate to the best of my knowledge. I understand the risks associated with hormone replacement therapy include but are not limited to:

- Stroke
- Heart Attack
- Infertility
- Blood clots
- Exacerbation of undiagnosed/pre existing cancer

I authorize this office and its staff to examine and treat my condition as the provider sees fit. I hereby authorize the provider to release all information to any insurance company, attorney, or adjuster for the purpose of claim of reimbursement. I understand and agree that all services rendered to me will be charged to me and I am responsible for timely payment of such services. I understand that fees for professional services will become immediately due upon suspension or termination or my care or treatment.

Patient Signature: _____
Date:_____

I consent to get text notifications:

_____

I do not consent to get text notifications:

_____