PATIENT INFORMATION

Last Name____________________________ **First Name**______________________________ **Middle Name**__________________________

Preferred Name_________________________ **Maiden Name**___________________ **Preferred Pharmacy& Address** __________________________

Date of Birth_____________________ **Social Security #**___________________________ **Primary Language** ___**English** ___**Spanish**

Marital Status:_____________________________ **Driver's License** State________# ______________________________

Race: ___African American ___American Indian ___Asian ___Caucasian ___Hispanic ___Other

Religion: ___Catholic ___Protestant ___Hindu ___Islam ___Jewish ___Buddhist ___Other

Address:____________________________________ **ZIP**___________ **City**__________________ **State**______

Primary Phone:__________________________ **Work Phone**_______________________ **Cell Phone**________________________

Fax Number____________________ **Pager Number**_____________________ **E-mail**___________________________________

Employer:__________________________ ___ Full Time ___ Part Time

Phone Or Ext______________________________ **Hire Date**_________________ **Occupation**_________________________

PARENT OR SPOUSE (Circle One) INSURED INFO:

Last Name____________________________ **First Name**______________________________ **Middle Name**__________________________

Preferred Name______________________________ **Maiden Name**____________________________

Date of Birth_______________________________ **Social Security #**______________________ **Primary Language** ___ **English** ___ **Spanish**

Marital Status:________________________________ **Driver's License** State________# ______________________________

Address: ___________________________________ **ZIP**_____________ **City**_____________________ **State**______

Primary Phone: ______________________ **Phone**______________________ **Cell Phone**___________________________

Work

Fax Number____________________ **Pager Number**_____________________ **E-mail**___________________________________

Employer: ________________________ ___ Full Time ___ Part Time

Phone Or Ext___________________________ **Hire Date**_________________ **Occupation** ________________________________

EMERGENCY CONTACT:

Last Name____________________________ **First Name**______________________________ **Middle Name**__________________________

Preferred Name_____________________________ **Maiden Name**__________________________ **Date of Birth & Relationship**__________________

Address:________________________________ **ZIP**____________**City**_________________________**State**________

Primary Phone:_______________________ **Work Phone**__________________________ **Cell Phone**___________________________

PATIENT MEDICAL HISTORY - Please attach additional pages if necessary

Name: ______________________________

Surgical History

Please list all surgeries you have had.

Procedure	Date

Current Medications

Please list all prescription, herbal, & over the counter medication you are currently taking.

Medication	Dosage & Frequency	Prescribing Physician

Allergies

Please list any medications you are allergic to & reaction

Medication	Reaction

Are you allergic to Latex? _____ Yes ______ No

Please list any other allergies (food, environment) that you have:

____

____

Menstrual History (as applicable)

_____ Age of Onset

_____Age of Menopause

_____Number of Pregnancies

_____Number of Miscarriages

_____Number of Living Children

_____Number of Elective Abortions

_____/_____/_______ Date of last period

_____ Length of flow (days)

_____Interval (days between periods)

Multiple Births (Twins etc) _____ Yes ______ No

_____Number of Spontaneous Miscarriages

PATIENT MEDICAL HISTORY - Please attach additional pages if necessary

Name: ____

Currrent & Past Medical Diagnosis

Please list all medical conditions you have or have had diagnosed.

Description	Date or Age Diagnosed	Current / Past
		____Current ____ Past
		____Current ____ Past
		____Current ____ Past
		____Current ____ Past
		____Current ____ Past
		____Current ____ Past
		____Current ____ Past
		____Current ____ Past
		____Current ____ Past

Have you ever smoked? _____ Yes ______ No

If yes, are you currently smoking? _____Yes _____ No

Amount smoked per day ___________________________

Do you drink alcohol? ______ Yes ______ Never _______ Occasionally

If yes, number of drinks per week/month (circle one) _________

Have you ever used recreational/street drugs? ______ Yes ______ No

If yes, what kind? ____

Family History

Please list any medical conditions of immediate family members

Mother		
Father		
Grandmother (Maternal)		
Grandfather (Maternal)		
Grandmother (Paternal)		
Grandfather (Paternal)		
Aunts		
Uncles		
Brothers		
Sisters		

Patient Name:______________________

Patient HIPAA Questionnaire

1. Please list anyone whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

Name	Phone #	Relationship to Patient
___________________	__________________	______________________
___________________	__________________	______________________

2. Please print the address you want your billing statements and/or correspondence from our office to be sent if other than your home.

   ____

3. We routinely leave messages (i.e. appointment reminders or requests to call our office back) on telephone answering machines or voicemail? If you do not want these messages handled in this fashion, indicate otherwise.

____

Patient Signature (Guardian if under 18)_________________________
Date _______

IF THE PATIENT IS UNDER 18, AND NOT PREGNANT, A PARENT OR GUARDIAN MUST COMPLETE THE CONSENT TO TREAT BELOW:

I am the parent/legal guardian of ______________________________ who is a minor.
I give my permission for Dr. Libson to provide complete medical care for her.

Signed ______________________________________ Date _______________

Patient Financial Policy

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and Sign)

I hereby authorize Dr. David S. Libson to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. If I fail to provide the correct insurance or Medicaid/Medicare information to the office, I understand I will be responsible for any amount not paid by third party carriers.

Signature______________________________ Date__________________