New Patient Information Form

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Birthdate _____

Email _____

Spouse's name _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Medical History

Physician _____ Date of Last Visit _____

Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any operations? _____
Yes No Have you ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hay Fever	Fibromyalgia	HIV / Aids	Rheumatic Fever
Bone Disorders	GERD or Acid Reflux	Insomnia	Thyroid Problem
Chronic Sinus Problems	Heart Murmur	Joint Replacement	Tuberculosis
Congenital Heart Defect	Heart Problems	Kidney problems	Tumor or Cancer
Congestive Heart Failure	Heart Valve Replacement	Migraines or Headaches	Tonsillectomy
Currently Pregnant		Nervous Disorders	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

_____

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_____

Signature: _____ Date: _____