

TODAY'S DATE: _____

PATIENT INFORMATION:

___ Single ___ Married ___ Other

NAME: _____ BIRTHDATE: ___/___/___ SEX: M F
First Middle Last

ADDRESS: _____
Number Street

EMAIL ADDRESS: _____
City State Zip Code

HOME PHONE: (____) _____ CELL PHONE: (____) _____ WORK PHONE: (____) _____

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___ CHILD

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Number Street City State Zip Code

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

RESPONSIBLE PARTY INFORMATION:

RELATIONSHIP TO PATIENT: ___ SELF ___ SPOUSE ___ PARENT ___ OTHER

NAME: _____ BIRTHDATE: ___/___/___ SEX: M F
First Middle Last

ADDRESS: _____
Number Street City State Zip Code

HOME PHONE: (____) _____ CELL PHONE: (____) _____ WORK PHONE: (____) _____

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___ CHILD

EMPLOYER: _____ OCCUPATION: _____

WORK ADDRESS: _____
Number Street City State Zip Code

SOCIAL SECURITY NUMBER: _____ DRIVER'S LICENSE NUMBER: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER: _____ GROUP/POLICY NUMBER: _____

SECONDARY INSURANCE: _____ SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NUMBER: _____ GROUP/POLICY NUMBER: _____

DO YOU HAVE ANOTHER HEALTH BENEFIT PLAN? ___ YES ___ NO
IS YOUR CONDITION RELATED TO: ___ EMPLOYMENT ___ AUTO ACCIDENT ___ OTHER ACCIDENT

WHO REFERRED YOU TO OUR OFFICE? _____

NAME OF YOUR FAMILY DOCTOR: _____
Name Phone number or city where practice is located

IN CASE OF EMERGENCY, NOTIFY: _____
RELATIONSHIP: _____ PHONE NUMBER: _____

I authorize Dr. Bresnick and staff to give me reasonable and proper medical care by today's standards.
I, the patient or responsible party, authorize release of medical information for the purpose of processing medical claims.
I also authorize my insurance company to pay benefits directly to Stephen D. Bresnick, M.D., Inc.
I authorize Dr. Bresnick to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

SIGNATURE: _____ DATE: _____

NAME: _____ AGE: _____ SEX: _____ WT: _____ HT: _____' / _____''

<u>HAVE YOU HAD, OR DO YOU STILL HAVE:</u>	<u>YES</u>	<u>NO</u>	<u>HAVE YOU HAD, OR DO YOU STILL HAVE:</u>	<u>YES</u>	<u>NO</u>
COLD OR COUGH WITHIN THE LAST TWO WEEKS			ALLERGIES OR UNFAVORABLE REACTIONS TO ANY MEDICATIONS OR SUBSTANCES _____ _____		
BREATHING PROBLEMS (ASTHMA, ETC.)					
CHEST PAINS OR ANGINA					
HEART PROBLEMS					
PALPITATIONS, IRREGULAR OR FAST HEARTBEAT			SURGERY (PLEASE LIST TYPE AND DATES) INCLUDE ALL COSMETIC SURGERY _____ _____		
SHORTNESS OF BREATH AT ANY TIME					
HIGH BLOOD PRESSURE					
ANY CIRCULATORY PROBLEMS					
BLOOD DISEASE (ANEMIA, ETC.)			ANY MEDICATION OR PILLS WITHIN 3 YEARS (PLEASE LIST) _____ _____		
BLEEDING PROBLEMS					
ANY IMMUNE PROBLEMS OR DISEASE					
LIVER DISEASE (HEPATITIS, JAUNDICE, ETC.)					
STOMACH PROBLEMS (ULCERS, ETC.)			DO YOU TAKE ASPIRIN, ADVIL OR OTHER ANTI-INFLAMMATORY MEDICATIONS		
INTESTINAL PROBLEMS					
NECK OR BACK PAIN OR INJURIES					
SEIZURES					
HEADACHES			HAVE YOU EVER SMOKED HOW MUCH PER DAY _____ YEARS _____ IF YOU'VE QUIT, WHEN _____		
STROKE OR TEMPORARY PARALYSIS					
PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT			DO YOU DRINK ALCOHOL HOW MUCH PER WEEK _____		
ANY VISUAL OR EYE PROBLEMS (DRYNESS, ETC.)					
GLASSES OR CONTACT LENSES			WHEN WAS YOUR LAST PHYSICAL EXAM _____		
DIABETES					
THYROID PROBLEMS			WHEN WAS YOUR LAST MENSTRUAL PERIOD _____		
KIDNEY OR BLADDER PROBLEMS					
ANY PROBLEMS DURING PREGNANCY			HAVE YOU BEEN TOLD YOU HAVE ANY OTHER DISEASES NOT MENTIONED ABOVE? IF YES, PLEASE LIST THEM: _____ _____		
PROBLEMS WITH ALCOHOL OR DRUG ABUSE					
WEIGHT CHANGES IN THE PAST YEAR					
CONNECTIVE TISSUE DISEASE (LUPUS, RHEUMATOID ARTHRITIS, SCLERODERMA, ETC.)					
COLD SORES OR OTHER HERPES INFECTIONS					
CANCER OF ANY TYPE					

IS IT OKAY WITH YOU TO SEND A THANK YOU NOTE TO THE PERSON WHO REFERRED YOU TO US? ___ YES ___ NO

WHO IS YOUR PERSONAL PHYSICIAN? _____ CITY OF HIS/HER PRACTICE: _____

PERSONAL INFORMATION

INITIAL CONSULTATION