Patient Information

Name:_____ Date:_____

Gender: Male/Female: _____ DOB: _____ SS#: _____

Address:_____Apt#:___City_____Zip Code_____

Home #:_____ Work#:_____ Cell#:_____

Email: _____

Pharmacy Name and Address: _____

Insurance Information:

Insurance Name: _____ Policy Holder Name: _____

Policy Holder SS#:_____ ID#:_____ D.O.B_____

Patient Relationship: _____

Medical Information: Please Circle all that Apply and list any other conditions:

Asthma	**Heart Disease/Condition**	
Bleeding Disorder	**Hepatitis/Jaundice**	**Mitral Valve Prolapse**
Cancer	**High Blood Pressure**	**Prosthetic Devices**
Chemotherapy	**Immune Disease**	**Rheumatic Fever**
Diabetes	**Leukemia**	**Thyroid Disease**
HIV/AIDS	**Low Blood Pressure**	**Anemia**

Have you ever had an unusual reaction to any of the following?

Aspirin Codeine Dental Injection Erythromycin Ibuprofen Penicillin/Amoxicillin

Any other allergies please list/explain?

_____

List of medications currently taking?

_____

Are you currently taking any form of blood thinners? If yes please list:

_____

Do you have any other Medical problems not listed or mentioned? Yes ____ No ____If yes please explain:_____

_____

Are you pregnant? Yes _____No _____ If yes, how far along? _____

Nursing? Yes _____ No_____ Taking Contraceptives? Yes _____ No _____

Are you currently under the care of a physician? If yes please provide Drs Information

Drs Name: _____ Drs Phone Number**:** _____

Have you had any recent surgeries or joint replacements? Yes _____ No _____

If yes please explain:

_____

_____

Surgeons Name**:**_____ Phone Number**:**_____

Date of surgery**:**_____ Do you Require Premedication: **Yes**____ **No** ____

Patient Name:_____ **Signature:**_____

Parent or guardian signature:_____ **Date:**_____