Patient Name: _____ **DOB:** ___/____/____ **Social Security #:** ____-___-_____
Last, First, Middle Initial *MM/DD/YYYY*

Mailing Address: _____ Physical Address: _____

_____ _____
City, State, Zip City, State, Zip

Home Phone: (_____) _____ Cell/Message: _____
May we leave a confidential message at this number? ☐ Yes ☐ No May we leave a confidential message at this number? ☐ Yes ☐ No

Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated Driver's License # _____ State _____ Exp ____

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Emergency Contacts: _____ Phone: _____ Relationship: _____

Insurance Information:

Primary Insurance Name: _____ **Policy Number:** _____

Policy Holders Name: _____ Effective Date: ___/____/_____ Group Number: _____
MM/DD/YYYY

Policy Holder SS#: _____-_____-_____ DOB: ___/____/____ **Employer:** _____
MM/DD/YYYY

Policy Holder Mailing Address: _____

_____, _____ _____-_____
City State Zip Code

Secondary Insurance: _____ **Policy Number:** _____

Policy Holders Name: _____ Effective Date: ___/____/_____ Group Number: _____
MM/DD/YYYY

Policy Holder SS#: _____-_____-_____ DOB: ___/____/____ **Employer:** _____
MM/DD/YYYY

Policy Holder Mailing Address: _____

_____, _____ _____-_____
City State Zip Code

Tertiary (Other Insurance: _____ **Policy Number:** _____

Policy Holders Name: _____ Effective Date: ___/____/_____ Group Number: _____
MM/DD/YYYY

Policy Holder SS#: _____-_____-_____ DOB: ___/____/____ **Employer:** _____
MM/DD/YYYY

Policy Holder Mailing Address: _____

_____, _____ _____-_____
City State Zip Code

Prior Primary Care Provider (PCP): _____
Name City/Location

Preferred Pharmacy: _____
Name City/Location

Current Medications:

Medication	Dose	Frequency	Started	Stopped	MD	Purpose

Allergies: (Food, Medications, Other):

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Past Medical History:

Illness	Date	MD	Notes

Past Surgical History:

Procedure	Date	MD	Hospital	Notes

Vaccinations:

Name	Date	Name	Date
Tetanus, Diphtheria, Acellular Pertussis (DTaP)		**Human Papilloma Virus (HPV)**	
Pneumonia Vaccine		**Meningitis Vaccine**	
Yellow Fever		**Polio**	
Hepatitis A		**Hepatitis B**	
Influenza Vaccine		**Measles/Mumps/Reubella (MMR)**	
Other Vaccination		**Other Vaccination**	

Family History: (Major Illnesses or Diseases)

Relationship to Patient	Disease	Living/Deceased	Age at time of death
Mother (Maternal)			
Father (Paternal)			
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Aunts/Uncles:			
Children:			

Social History:

Tobacco: □ Yes □ No
Amount: _____
Date Started: _____

Alcohol: □ Yes □ No
How Often: _____
How Much: _____

Recreational Drugs: □ Yes □ No
Type/Frequency: _____
Date Started: _____