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FOR OFFICE USE ONLY

Referring Doctor _____ Account # _____

PATIENT INFORMATION

Please respond to each item - *Please Print*

Date _____

Patient's Name _____
LAST FIRST MIDDLE

Address _____
NUMBER STREET CITY STATE ZIP

Sex _____ Date of Birth ____/____/____ SS # _____

Home Phone (____) _____ Cell Phone _____ email address _____

Patient's Employer _____ Position _____ Bus. Phone _____

Marital Status _____ Spouse _____ Spouse's SS # _____

Spouse's Employment _____ Position _____ Bus. Phone _____

IF PATIENT IS A MINOR - Guarantor/Billing Information:

Name _____ Relationship to Patient _____ SS # _____ DOB ____/____/____

Address _____
NUMBER STREET CITY STATE ZIP

Name of Employer _____ Position _____ Bus. Phone _____

NOTIFY IN CASE OF EMERGENCY (other than spouse)

Relationship _____ Home Phone _____ Bus. Phone _____

Address _____
NUMBER STREET CITY STATE ZIP

Referred By _____ Address _____

INSURANCE INFORMATION



FRONT COPY OF CARD
(For Office Use Only)

BACK COPY OF CARD
(For Office Use Only)



As a participating Medicare provider, we will file your claim to Medicare. We also file claims only to those managed care companies with which we participate. **I understand that I am financially responsible for all charges incurred for services rendered at time of treatment.**

I authorize Dr. Farris to release medical information that may be necessary for claim reimbursement from those insurance companies listed.

Signature _____ Date _____

MEDICAL HISTORY

Name _____ Date _____

Reason for Visit _____

Do you have or have you recently had any of the following problems?

- | | | |
|--|--|---|
| <u>Y</u> <u>N</u> Fever | <u>Y</u> <u>N</u> Swollen glands | <u>Y</u> <u>N</u> Discoloration of hands & feet |
| <u>Y</u> <u>N</u> Headaches/migraine | <u>Y</u> <u>N</u> Asthma | <u>Y</u> <u>N</u> Diabetes |
| <u>Y</u> <u>N</u> Sore throat | <u>Y</u> <u>N</u> Chest pain | <u>Y</u> <u>N</u> Burning on urination |
| <u>Y</u> <u>N</u> Sinus problems | <u>Y</u> <u>N</u> Runny nose/hay fever | <u>Y</u> <u>N</u> Varicose veins |
| <u>Y</u> <u>N</u> Irregular heart beat | <u>Y</u> <u>N</u> Diarrhea | <u>Y</u> <u>N</u> Hives |
| <u>Y</u> <u>N</u> Shortness of breath | <u>Y</u> <u>N</u> Discoloration of stool | <u>Y</u> <u>N</u> Changing or bleeding moles |
| <u>Y</u> <u>N</u> Seasonal allergies | <u>Y</u> <u>N</u> Hepatitis | <u>Y</u> <u>N</u> Last Tet. Shot |
| <u>Y</u> <u>N</u> Nausea/vomiting | <u>Y</u> <u>N</u> Frequency of urination | <u>Y</u> <u>N</u> Alcohol use |
| <u>Y</u> <u>N</u> Weight loss/gain | <u>Y</u> <u>N</u> Swelling of legs | <u>Y</u> <u>N</u> Cigarettes |
| <u>Y</u> <u>N</u> Red irritated eyes | <u>Y</u> <u>N</u> Skin rashes | <u>Y</u> <u>N</u> Drug use |

List all significant medical illnesses or injury with year of occurrence Hospitalizations & year of occurrence

- _____ 1. _____
- _____ 2. _____
- _____ 3. _____

Have you ever had a skin cancer or malignant melanoma? Yes / No

If yes, please explain _____

Medications

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Drug allergies:

Family History

	<u>Age</u>	<u>Health Status</u>	<u>Deceased (give cause)</u>
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____