

Name: _____

Date of Birth: _____

Race: _____

(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____

Preferred Language: _____

Privacy Information Preferences:

Where you offered a copy of the HIPAA Privacy Practice Notice? Yes No

** (Please ask the front desk if you would like to see it)

Can we send mail to the address on file? Yes No

Can we call the phone number on file? Yes No

Can we leave voicemail on answering machine? Yes No

Will you allow internet based delivery reminders like email? Yes No

Who can we leave messages with? Wife Husband Daughter Son

Other:

Smoking Status

Current Every Day Smoker

Current Some Day Smoker

Former Smoker

Never Smoker

Vital Signs

Blood Pressure: _____ / _____

Height: _____

Weight: _____

Current Medications None

If you have a list we can make a copy

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Name: _____ Dose _____

Use the back of this form if more room is needed

Allergy

Reaction

No Known Allergies

Penicillin

Shellfish

Sulfa

Tape

Latex

Betadine (Iodine)

Aspirin

Tylenol™

Ibuprofen

Codeine

Other (specify) _____

Please read and sign

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

(patient signature)