

In the interest of keeping all records current and accurate, please complete the following:

Patient Name: _____ Date: ____/____/____

Address: _____

Telephone Number(s)

Home: _____ Work: _____ Cellular: _____

E-Mail Address: _____

Insurance: PRESENT CARD

Primary Care Physician: Name, Address, Telephone #: _____

List ALL Current Medications: PLEASE WRITE CLEARLY & LEGIBLY TO ENSURE THE ACCURACY OF YOUR PATIENT RECORD.

Do you smoke? _____ (circle: cigarettes, cigar, pipe) How often? _____

Did you smoke? Yes No When did you stop? _____

Do you drink? _____ If so, how many drinks per week? _____

Patient Signature _____ Date of Birth _____