code: GF006

Patient Demographics

Date _____

Patient Information:

First Name	**Middle Name / MI**	**Last Name**	**Sex**
Date of Birth	**Home Phone**	**Cell Phone**	**Preferred Phone**
Patient Address Line 1	**Patient Address Line 2**		
City	**State**	**Zip**	
Email	**Language**	**Communication Preference**	**Ethnicity**
Religion	**Race**	**Marital Status**	
Spouse's Name	**Spouse's Contact Phone**		
Patient Employment Status	**Professional Title**	**Employer Name**	
Work Phone	**Fax Number**		
Employer Address Line 1	**Employer Address Line 2**		
Employer City	**Employer State**	**Employer Zip**	

Primary Insurance Information:

Primary Insured's Name	**Date of Birth**

Primary Relationship to Insured

Primary Insured's SSN

Insured's Home Phone

Cell Phone

Work Phone

Driver's License #

Primary Insurance Name

Primary Plan Name

Primary Subscriber ID

Primary Group No.

Secondary Insurance Information:

Secondary Insured's Name

Date of Birth

Secondary Relationship to Insured

Secondary Insured's SSN

Insured's Home Phone

Cell Phone

Work Phone

Driver's License #

Secondary Insurance Name

Secondary Plan Name

Secondary Subscriber ID

Secondary Group No.

Emergency Contact:

Emergency Contact Name

Emergency Contact Relationship to Patient

Emergency Contact Home Phone

Emergency Contact Cell Phone

Emergency Contact Work Phone

Emergency Contact Address Line 1

Emergency Contact Address Line 2

Emergency Contact City

Emergency Contact State

Emergency Contact Zip

Primary Physician Name

Primary Physician Phone

Whom may we thank for referring you?

Health History

Current medical conditions:

Month/Year Diagnosed	Medical Problem	Treatment/Medication
1)	_	_
2)	_	_

3)	_	_
4)	_	_

Surgeries:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Hospitalizations:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Medications:

Name of Drug	Strength	Frequency Taken
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Allergies

Name	Reaction
1)	_
2)	_
3)	_
4)	_

Exercise:

Type	Intensity	Frequency
Type	Intensity	Frequency

Social History

Caffeine:

Caffeine Beverage?	Type (coffee, tea, soda, etc.)	Amount	Frequency

- Yes
- No

Alcohol:

Alcoholic Beverage?	Frequency	Amount

- Yes
- No

Smoking Status

Patient Smoking Status	Patient Smoking Frequency	Patient Smoking Start Date	Patient Smoking End Date

Do you currently use recreational or street drugs?

- Yes
- No

Have you ever given yourself street drugs with a needle?

- Yes
- No

Family History

List medical illness and/or cause of death:

Mother

_____

Father

_____

Brother/Sister

_____

Husband/Wife

_____

Son/Daughter

_____

Additional Comments

_____

Date

_____

Signature of Responsible Party