code: GF006

Patient Demographics

Date _____

Patient Information:

First Name _____ Middle Initial _____ 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

_____

Signature of Responsible Party

Date

_____