Patient's Information

Name _____ SS# _____

Mailing Address _____ Date of Birth _____

City _____ State _____ Zip _____ Sex: M / F

Home Phone # _____ Cell # _____

Email Address _____ Marital Status: S M W Sep D

Primary Language _____ Race _____ Ethnicity _____

Emergency Contact _____ Tel# _____ Relationship _____

Patient's Employer Information pharmacy'.

Employer _____ Tel # _____

Address _____ City/State _____

Spouse's Information (if applicable)

Spouse's Name _____

Spouse's Employer & Address _____

Insurance Information

Primary Insurance Company Name _____

Group # _____ ID # _____ Tel # _____

Subscriber's Name (Name on the card) _____ Subscriber's D.O.B. _____

Subscriber's Employer _____ Relationship to Patient _____

Secondary Insurance Company Name _____

Group# _____ ID# _____ Tel # _____

Subscriber's Name (name on the card) _____ Relationship to patient _____

Medical Information Release and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Signature _____ Date _____

(Patient / Parent / Guardian)

I hereby authorize Dr. E. A. Keel, or any covering physician, to apply for benefits on my behalf for covered services Rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. E. A. Keel, or any covering physician.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature _____ **Date** _____

(Patient / Parent / Guardian)

Patient's Name_____ SS#_____

General Medical Information

Describe the reason for today's visit_____

Present medications_____

Are you allergic to any medications? Y or N If so please list _____

Allergies (itchiness or hives) to specific brands of soap/laundry detergent _____

Other physicians currently treating you _____

Previous or other medical problems_____ _____

List any previous surgeries or hospitalizations (include miscarriages & live births)_____

Females only: Are you pregnant, planning a pregnancy or nursing a child? Y or N
Do you smoke? Y or N ___Cigarettes ___Pipe ___Cigars Amount per day_____ # of years_____
Do you regularly drink alcohol? Y or N Amount per day _____
Do you regularly drink coffee? Y or N Cups per day_____

Personal Medical History (check all that apply)

___Chest pain
___Hypertension
___Heart Attack
___Stroke
___Headaches
___Glaucoma
___Allergies
___Depression
___Blood in stool
___Asthma
___Dizziness
___Cancer
___Diabetes
___Arthritis
___Memory Loss
___Hemorrhoids
___Kidney Disease
___Ulcers
___Difficulty Hearing
___Shortness of Breath
___TB/Lung Disorder
___Skin Disorders
___Hepatitis
___Digestive Problems
___Urinary Infections
___Other:_____

Immunizations

(year last received, if known)
Smallpox_____
Tetanus_____
Typhoid_____
Polio_____
Influenza_____
Pneumonia_____
Rubella_____
Hepatitis_____

Family History

	Mother or Father's side of the family	Relationship to person with medical condition.(father, mother, grandparent, Sibling or child)
High blood pressure	M or F	_____
Epilepsy	M or F	_____
Cancer	M or F	_____
Eczema/Psoriasis	M or F	_____
Heart Attack/Stroke	M or F	_____
Diabetes	M or F	_____
Asthma	M or F	_____
Hay Fever	M or F	_____