PATIENT INFORMATION

NAME _____DATE OF BIRTH_____AGE____
ADDRESS_____
CITY_____STATE _____ZIP_____
SEX _____ MARITAL STATUS_____
EMAIL: _____

HOME PHONE:_____CELL:_____
EMERGENCY NAME/PHONE: _____

PATIENT'S OCCUPATION _____
EMPLOYER_____BUSINESS PHONE: _____

NAME OF SPOUSE_____
SPOUSE'S OCCUPATION: _____
EMPLOYER_____PHONE_____

IF PATIENT IS A MINOR, NAME OF PARENT_____
EMPLOYER_____ BUSINESS PHONE_____

HOW DID YOU HEAR ABOUT DR. MARSHAK? _____
WHAT IS THE NATURE OF YOUR VISIT? _____

GENERAL PATIENT MEDICAL HISTORY

1. What is your general state of health? ☐ Excellent ☐Good ☐Fair ☐Poor
2. ☐ YES ☐ NO Do you have any known heart, lung, blood pressure, or diabetic problems? If yes, please explain. _____
3. ☐ YES ☐ NO Are you under the care of a physician now? If yes, for what reason? _____
4. Name and contact information of personal physician: _____
5. List ALL medications and tablets you take by mouth, on a DAILY basis (include dosage). _____
_____
6. ☐ YES ☐ NO Are you taking aspirin or aspirin containing compounds? If yes, please list with dosage: _____
7. ☐ YES ☐ NO Do you have **allergies** to any medications? If yes, please specify and include reactions that occurred and when. _____

8. ☐ YES ☐ NO Have you or any relative ever had a bad reaction to a local or general anesthetic? Please explain. _____
9. ☐ YES ☐ NO Do you smoke cigarettes? If yes, how many per day? _____
10. ☐ YES ☐ NO Do you drink alcoholic beverages? If yes, please specify type and amount per day or week. _____
11. ☐ YES ☐ NO Have you ever had a diagnosis of cancer? If yes, please explain.

_____

12. ☐ YES ☐ NO Have you ever had hepatitis? If yes, what type? A, B, or C _____; When? _____ How did you acquire it? _____
Do you currently have any symptoms? _____ Are you still a carrier? _____
13. ☐ YES ☐ NO Have you ever been diagnosed as having AIDS or HIV, If yes, please explain._____
14. ☐ YES ☐ NO Are you subject to profuse bleeding? If yes, please explain.

_____

15. ☐ YES ☐ NO Have you ever had Bell's Palsy or facial herpes infection? Are you prone to facial cold sores? If yes, how often and how do you treat them?

_____

16. FOR FEMALE PATIENTS:
☐ YES ☐ NO Are you pregnant or nursing? If yes, please explain.

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17. ANY OTHER MEDICAL PROBLEMS YOU HAVE NOT INDICATED ABOVE?

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18. Is there anything else you would like to tell the doctor at this time?

_____

PATIENT RIGHTS AND RESPONSIBILITIES:

A list of Patient Rights and Responsibilities is available at the front counter for me to take.

INSURANCE AUTHORIZATION:

I authorize Harry Marshak, MD, to bill my health insurance and to receive all payments directly for services rendered. I will be held responsible for all deductibles and copays, which are determined by the individual carrier. I authorize the release of my benefits and eligibility to Harry Marshak, MD.

_____ _____
PATIENT SIGNATURE (or responsible party) DATE