PATIENT TREATMENT RECORD

Account No. ______________

Gender

Male ☐

Female ☐

Relationship to *Responsible Party ______________

Patient (full name) ______________

Address ______________

City ______________ St. ______ Zip ______

Ins. Cov. ______________ ☐

Referred by ______________

E-Mail Addr. ______________

Responsible Party ______________

Business Name & Addr. ______________

S.S. No. (Responsible Party) ______________

☐ Previous Addr. ☐ C/O Addr. ☐ Other ______________

Phones

Home ______________ Business ______________

Cell ______________ Other ______________

Payment Method: ☐ Insurance ☐ Cash ☐ Check ☐ Cr. Card

Office Use Only ______________

MEDICAL HISTORY

Birth Date ______________

S.S. No. ______________

Primary Physician ______________ Last visit date ______________ Phone No. ______________

Are you currently under the care of a doctor? ☐ Yes ☐ No If yes, explain ______________

Have you been a patient in a hospital in the last 5 years? ☐ Yes ☐ No If yes, explain ______________

Do you have, or have you had, any of the following? (please answer all questions)

	YES	NO
1. Heart Disease	☐	☐
2. Heart Attack	☐	☐
3. Angina (chest pain)	☐	☐
4. Cardiac Pacemaker	☐	☐
5. High Blood Pressure	☐	☐
6. Low Blood Pressure	☐	☐
7. Anemia	☐	☐
8. Rheumatic Fever	☐	☐
9. Heart Murmur	☐	☐
10. Diabetes	☐	☐
11. Stroke	☐	☐
12. Epilepsy	☐	☐
13. Thyroid Disease	☐	☐
14. Fainting	☐	☐
15. Seizures	☐	☐
16. Arthritis	☐	☐
17. Asthma	☐	☐
18. Do you smoke?	☐	☐
19. Emphysema	☐	☐
20. Tuberculosis	☐	☐
21. Sinus Trouble	☐	☐
22. Hay Fever	☐	☐
23. Kidney Disease	☐	☐
24. Liver Disease	☐	☐
25. Hepatitis	☐	☐
26. Jaundice	☐	☐
27. Leukemia	☐	☐
28. Excessive Bleeding	☐	☐
29. Blood Disorders	☐	☐
30. Radiation Treatment	☐	☐
31. Allergic to, or reaction to:	☐	☐
a. Penicillin	☐	☐
b. Sulfa Drugs	☐	☐
c. Other Antibiotics: ______	☐	☐
d. Local Anesthetic	☐	☐
e. Novocain	☐	☐
f. Aspirin	☐	☐
g. Barbiturates	☐	☐
h. Other Sedatives: ______	☐	☐
i. Iodine	☐	☐
j. Latex Rubber	☐	☐
k. Other: ______	☐	☐
32. Sexually Transmitted Disease	☐	☐
33. Psychiatric Treatment	☐	☐
34. Do you wear Contact Lenses?	☐	☐
35. Have you taken any steroid medication within the last 2 years?	☐	☐
36. For Woman: Are you pregnant?	☐	☐
37. Have you had Organ Transplant, or Artificial Bone/Joint, or Valve replacement?	☐	☐

38. Have you tested positive for HIV/AIDS virus? ☐ YES ☐ NO 39. Are you taking any medications? ..... ☐ YES ☐ NO If yes, explain (below)

40. Do you have any disease or conditions not listed above that you think I should know about? ..... ☐ YES ☐ NO If yes, explain (below)

Comments: ______________

Changes in Medical Health, (please record above code number(s) relating to the changes).

DATE	PATIENT'S SIGNATURE	#	DATE	PATIENT'S SIGNATURE	#
		☐			☐
		☐			☐

HIPAA Acknowledgement (Patient) X ______________ Date ______________