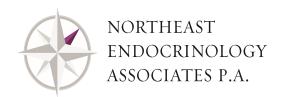


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Patient Information Form

Please fill out the following information so we can update your chart.

Patient Name:	,						
Last	First			Preferred Name			
Social Security Number://	Date of 1	Birth:/	/ Sex:	□ Male	☐ Female		
Address:							
Street	City	State	Zip				
Cell phone:l	Email:						
Race: □ Caucasian □ Asian □ Africa □ Native American □ Native Hawaiian □			1		L		
Preferred Language : ☐ English ☐ Spanish	□Vietnamese	Other					
Ethnicity: Hispanic or Latino Not Hisp	oanic or Latino 🗖	Jnknown /Not Re	ported				
EMERGENCY/HIPPA CONTACT							
Name: Pho	one: ()		Relation:				
Please check if:Authorized to release HIF	PPA Autho	rized to release fir	nancial informa	tion			
	INSURANC	E INFORMATIO	N				
PRIMARY INSURANCE INFORMATION:							
Name of Insurance:		Policy ID:					
Group Number:	Group Empl	oyer:					
Name of Policy Holder:	SSN#:		Date of Birth	: - _			
Policy Holder Relation to Patient: \square Self \square S	pouse Child	Other					
SECONDARY INSURANCE INFORMATIO							
Name of Insurance:		-					
Group Number:							
Name of Policy Holder:							
Policy Holder Relation to Patient: \square Self \square S	pouse \Box Child	□Other					
Preferred Pharmacy and phone number:							
ASSIGNMENT OF BENEFIT: I hereby authorize pa	avment directly to	nhysician of hono	fits due to mo f	or his/hor	services !		
understand I am financially obligated for charge		· ·					
other information necessary to process this claim		341.10712411011.		. 2.2432 01	an, meane		
Signature (Patient/Guardian):			Date	/	/		



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General Health Information

Welcome to our practice! Please take a moment to fill out the following health questions:

Patient Name: _				Today's Date: / /			
Preferred Name:							
			l problems - check all thos	se that apply:			
□ Diabetes	□ Diabetes □ Kidney stones □ Autoimmune Disease Type						
☐ Liver problen	ns 🗆	High blood pressure	☐ High cholesterol	☐ Cancer			
☐ Thyroid disea	se 🗌	Osteoporosis	Depression	☐ Specify:			
		Prior surgeries - ci	rcle all those that apply, giv	ve dates if possible:			
Cancer	//		☐ Thyroid Surgery	/ /			
		//		/ /			
		/ /		/			
Tobacco Use:	Curren	If	you have ever used tobacco	ttes/cigars			
If yes, how many	ncing low	blood sugars? □Yes					
Have you had	l a recer	nt eye exam? □	Yes No				
Date of eye exan	n:		//				
Eyes Dilated			Yes No				
Name of eye doc	tor:						
Have you been to	old you ha	ve diabetic eye chang	ges?				

Physician List

Please include Primary Care Physician and Referring Physician

Please identify those MD's that records are to be requested from: **Medication List** Please take the time to fill out all the information Name: Dose/Mg: **Directions:** Supplements or Vitamins: Dose/Mg: **Directions:** Name:

Please list all medications to which you are allergic:								
Patient Name:	Date:							