Patient Information

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Home Phone: _____ Cell: _____

Address: _____

Employer: _____ Position: _____

Employer Address: _____ Phone No. _____

Emergency Contact Information

Dependent? _____ If yes, Guardian's Name: _____

Guardian's Phone: _____ Cell: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone No. _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell _____

Insurance

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Phone No. _____

Address: _____

Policy NO. _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company: _____

Insured Party: _____ Relationship to Patient: _____

Phone No. _____ Address: _____

Policy No. _____ Group No. _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.
I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance Information I have provided is factual and correct.

_____ _____ _____

Patient Name | Patient Signature | Date

MEDICAL HISTORY FORM

Medical Chest Associates

PATIENT NAME	EMAIL

CURRENT PHYSICIAN NAME	PHONE

CURRENT PHARMACY NAME	PHONE

CURRENT MEDICATIONS

MEDICATION NAME	DOSAGE	FREQ.	MEDICATION NAME	DOSAGE	FREQ

SOCIAL HISTORY

SMOKER (Y/N)	
YEARS SMOKED	
PACKS PER DAY	
YEARS QUIT	
EXPOSURE HISTORY	

ALLERGIES

NAME OF DRUG	REACTION

MAJOR ILLNESSES

CURRENT DIAGNOSIS	START	END DATE

FAMILY HISTORY

RELATIONSHIP	DIAGNOSIS
MOTHER	
FATHER	
SIBLINGS	

Name

Signature