PATIENT INFORMATION (PLEASE PRINT) Acct. No. _____

Please complete the entire form

PATIENT'S NAME				S.S.#	CELL PHONE #
MARITAL STATUS		SEX	DATE OF BIRTH	AGE	HOME PHONE #	BUS. PHONE #
S M W D SEP		M F				
STREET ADDRESS				CITY AND STATE	ZIP CODE
PATIENT'S OR PARENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED
EMPLOYER'S STREET ADDRESS				CITY AND STATE	
REFERRED BY			HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE		
DRUG ALLERGIES, IF ANY					
SPOUSE OR PARENT'S NAME				RELATION TO PATIENT	SS #
SPOUSE OR PARENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)	
IN CASE OF EMERGENCY CALL				HOME PHONE	BUSINESS PHONE
PERSON RESPONSIBLE FOR PAYMENT IF NOT PATIENT				DATE OF BIRTH	STREET ADDDRESS, CITY, STATE	ZIP CODE
PRIMARY INSURANCE CARRIER & ADDRESS				NAME OF POLICY HOLDER & RELATION TO PATIENT	
STREET ADDRESS, CITY, STATE				POLICY #	GROUP #
SECONDARY INSURANCE CARRIER & ADDRESS				NAME OF POLICY HOLDER & RELATION TO PATIENT	
STREET ADDRESS, CITY, STATE				POLICY #	GROUP #
FAMILY PHYSICIAN			STREET ADDRESS, CITY, STATE, ZIP CODE		PHONE

PLEASE READ: All professional services rendered will be billed to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is ultimately responsible for all fees regardless of insurance coverage. It is customary to pay for services not covered by insurance when the services are rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE JOHN R. LOUGHREY, MD TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE

DATE _____ SIGNATURE _____

Medical History Questionnaire

Referring Physician: _____

Name: _____ Date of Birth: _____ Age: _____ Date: _____

❑ Male ❑ Female ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Family History:

	Alive	Deceased	Cause of Death		Family Member Affected
Father	❑	❑	_____	❑ Diabetes	_____
Mother	❑	❑	_____	❑ Cancer	_____
Brothers	❑	❑	_____	❑ Genetic Disease	_____
	❑	❑	_____	❑ Hypertension	_____
Sisters	❑	❑	_____	❑ Stroke	_____
	❑	❑	_____	❑ Heart Disease	_____

Health History

Operation or Illness	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List Any Drug Allergies: _____

Prescription Medications: _____ _____

_____ _____

_____ _____

_____ _____

Additional Health Questions:

❑ Weight Change
❑ Change in Exercise Tolerance
❑ Fever or Fatigue
❑ Hypertension
❑ Chronic Headache
❑ Change in Vision
❑ Glaucoma
❑ Change in Hearing
❑ Nasal Bleeding
❑ Teeth or Gum Problems
❑ Sore Throat
❑ Thyroid Condition
❑ Trouble Breathing
❑ Cough
❑ Chest Pains
❑ Irregular Heart Beat
❑ Diabetes
❑ Burning Urination
❑ Urinary Frequency
❑ Arthritis or Joint Pain
❑ Rash or Skin Condition
❑ Previous Stroke
❑ Seizure
❑ Depression
❑ Anxiety
❑ Bleeding or Clotting Disorder
❑ Tobacco Use
❑ Alcohol Use
❑ Aspirin Use
❑ NSAID Use
❑ Other