Patient Information Sheet

*Last Name*_____ *First*_____ *M.I.*_____

Home # _____ *Work #*_____ *Cell#*_____

*Address*_____ *City*_____ *State*_____ *Zip*_____

Preferred Contact # _____ *D.O.B*_____

*Social Security #*_____

Drivers license # _____ *E-mail address*_____

*Primary Language*_____ *Marital Status: Single Married Widowed Divorced Partner*

*Pharmacy Name*_____ *Pharmacy #*_____

Employer _____ *Occupation*_____

*Address*_____ *City*_____ *State*_____ *Zip*_____

Race _____ *(Caucasian ,Hispanic, African American)*

*Contact in case of emergency*_____ *Phone#*_____ *Relationship*_____

*How Do You Intend To Pay? Cash*_____ *Check*_____ *Insurance*_____ *Medicare*_____

*Primary Insurance*_____ *Policy Holder Name*_____ *DOB*_____

*Social Security*_____

*Whom May We Thank For Referring You To This Office*_____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled, Private insurance, and any other health plan to Argus Prohealth Partners.

ACKNOWLEDMENT AND AUTHORITY OF TREATMENT

I CONSENT TO TREATMENT AS NECESSARY OR DESIRABLE TO THE CARE OF THE PATIENT WHOSE NAME MENTIONED ABOVE.

Would you want information on advanced directives? YES NO

Patient's Signature _____ *Date*_____

NAME_____AGE_____D.O.B._____DATE_____

ALLERGIES PLEASE LIST)_____

_____

_____

CURRENT MEDS (LIST)

_____

_____

_____

LAST PHYSICAL EXAM: _____

FAMILY	LIVING		DECEASED		FAMILY HISTORY	
	AGE	HEALTH	AGE	CAUSE		WHO
MOTHER					ASTHMA	
FATHER					CANCER	
BROTHERS					TB	
					DIABETES	
					HEARTTROUBLE	
					HYPERTENSION	
SISTERS					STROKE	
					EPILEPSY	
					AIDS OR HIV	
					MENTAL ILLNESS	

SOCIAL HISTORY

ALCHOHOL INTAKE: DAILY____WEEKLY_____OCC._____NEVER_____
DRUGS: DAILY____WEEKLY_____OCC._____NEVER_____
CIGARETTES: YES_____NO_____PACK/DAY_____YEARS SMOKED_____

MEDICAL HISTORY:

MEDICAL
CONDITIONS_____

_____

SURGERIES_____

_____

_____

(WOMEN)
LAST MENSTRAL PERIOD_____MAMMOGRAM_____
#OF PREGNANCIES_____#OF CHILDREN_____#OF ABORTIONS_____
VAGINAL DELIVERIES_____C-SECTION_____

(MEN): LAST PROSTATE CHECK_____