



New Patient Information Record
Please Print Neatly!

Patient Name _____ E-mail _____

Age _____ DOB _____ Gender: M F Marital Status: M S W D SEP

Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone # _____

Employer _____ Occupation _____ Phone # _____

Work Address _____ City _____ State _____ Zip _____

Name of Spouse (Parent if Minor) _____ DOB _____

Emergency Contact _____ Phone # _____ Cell # _____

Primary Care Doctor's Name: _____ **Phone #** _____

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

Did anyone refer you here? Yes No If yes, who? _____

How did you hear about our office? Internet TV Radio Newspaper Ad Direct Mail Yellow Pages

Referral (physician/family/friend) Other (please specify) _____

Payment is expected when services are rendered. We accept cash, check, VISA, Mastercard and Discover.

Signature _____ Date _____

PLEASE TURN OVER AND COMPLETE SECOND SIDE

HEARING PROBLEMS

Do you currently have any hearing or ear problems? If yes, please be specific. _____

MEDICAL PROBLEMS

Do you have any current health problems? If yes, please explain briefly. _____

Are you under a physician's care? Yes No For what?

Do you smoke? Yes No

Are you pregnant? Yes No

Please list any medications that you are currently taking:

Please check any of the following you've had in the past or currently:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> AIDS/HIV/ARC	<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Angina Pectoris	<input type="checkbox"/> Hepatitis A (infectious)	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis B (serum)	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Hayfever	<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Fever Blisters	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> Sinus Trouble	<input type="checkbox"/> Anemia
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Allergies/Hives	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Heart Valve/Bypass	<input type="checkbox"/> Congenital Heart Lesions	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Trouble
<input type="checkbox"/> Heart Pacemaker	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pain in Jaw
<input type="checkbox"/> Venereal Disease			

Are you allergic to any medications or substances? If yes, please list. _____

Is there any other medical information we should know about? _____