PATIENT INFORMATION

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TODAY'S DATE: _____________ SS#_______________________

NAME: __________________________________ DATE OF BIRTH: __________

PHYSICAL ADDRESS:____

MAILING ADDRESS(IF DIFFERENT):______________________________________

CITY:___________________________ STATE_____________ ZIP:______________

TELEPHONE: (HOME)____________ (CELL) _____________ (WORK)_________

EMAIL ADDRESS: _____________________________________

HOW WOULD YOU LIKE TO BE NOTIFIED OF FUTURE APPOINTMENTS:
PHONE CALL_______ TEXT MESSAGE_________ EMAIL__________

SEX: ______ MARITAL STATUS:__________ SPOUSE NAME: _______________

PLACE OF EMPLOYMENT: ____

PERSON RESPONSIBLE FOR ACCOUNT (IF OTHER THAN THE PATIENT):
____

CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE EVER HAD:

A. High Blood Pressure
B. Heart Attack or Heart Trouble
C. Heart Valve Replacement
D. Pacemaker
E. Joint Replacement
F. Stroke
G. Acid Reflux (GERD)
H. Sleep Apnea
I. Cancer
J. Diabetes
K. Bleeding Problems
L. Hepatitis or Liver Disease
M. HIV/ AIDS
N. Tuberculosis
O. Kidney Problems
P. Stomach Ulcers
Q. Osteoporosis
R. Glaucoma
S. Sinus Problems
T. Asthma
U. COPD
V. Seizures
W. Psychiatric Problems
X. Allergies to ANY Medications
Y. Latex Allergy
Z. Tobacco Use

FOR WOMEN ONLY: ARE YOU PREGNANT? __________ NURSING?________

ARE YOU TAKING ANY MEDICATIONS? IF SO PLEASE LIST THEM:
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PLEASE LIST ANY PREVIOUS SURGERIES: _______________________________
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DO YOU TAKE OR HAVE YOU EVER TAKEN ANY MEDICATIONS FOR OSTEOPOROSIS (FOR YOUR BONES)? _____________________________

DO YOU SNORE OR HAVE YOU BEEN TOLD YOU SNORE? ______________

HAVE YOU HAD A SLEEP STUDY OR BEEN TOLD YOU NEED ONE?_______

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE TO THE BEST OF MY KNOWLEDGE: ____
SIGNATURE OF PATIENT OR PARENT/ GUARDIAN