

**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security# \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

(PLEASE CIRCLE AS APPLIES) SEX: F M SINGLE MARRIED DIVORCED WIDOWED OTHER

Who is your primary care physician: \_\_\_\_\_ Phone#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone # \_\_\_\_\_

HOW DID YOU HEAR OF US: \_\_\_ Billboard \_\_\_ US1 \_\_\_ Hazen Website \_\_\_ internet Search

Who referred you: \_\_\_\_\_ Other (Please explain) \_\_\_\_\_

Please Circle Yes or No:

Would you like to receive e-mails about specials? Yes No

Would you like to receive announcements by Mail Yes No

ADD E-MAIL ADDRESS \_\_\_\_\_

Reason for being seen today:

**MEDICAL HISTORY**

LIST ALL MEDICATION (include over the counter):

DO YOU HAVE A LATEX ALLERGY: YES NO PENICILLIN YES NO

PLEASE LIST ANY OTHER ALLERGIES:

LIST ALL PREVIOUS SURGERIES AND DATES:

Do You Smoke: YES NO How Much? How Long?

PLEASE CHECK AS IT APPLIES: Headaches Dizziness Hypoglycemia High/Low Blood Pressure

Thyroid Emphysema Asthma Heart Attack Stroke Diabetes HIV Hepatitis

Other:



PLEASE CIRCLE ONE:

WOULD YOU LIKE TO RECEIVE E-MAILS ABOUT SPECIALS?

YES

NO

WOULD YOU LIKE TO RECEIVE ANNOUNCEMENTS BY MAIL

YES

NO