New Patient Information Record

(Please Print or Write Legibly. Please complete as thoroughly as possible.)

Referred By:	Referring Phy Phone:	Your Driver's License#

Name:	Marital Status: S M W D Sep.	Date of Birth:	Age:	Social Security #:

Street Address:	City:	State:	Zip Code:

Home Phone:	Work Phone:	Mobile Phone:	Email Address:

Employed By: (Indicate if Retired)	Occupation: (Indicate If Student and Give Name of School)

Employer's Street Address:	City :	State:	Zip Code:

Person Responsible for Payment:	City, State & Zip Code:	Home Phone:

Spouse's Name:	Spouse's Social Security No.:

Spouse Employed By (Indicate if Retired)	Occupation (Indicate if Student)	How Long Employed:	Bus. Phone:

Medical History

Nature of Problem:	Date Problem Began:
List Previous Treatment (If Any) For This Problem And/Or X-Rays Taken:	
List Medications Allergic To:	

Emergency Contact Information

Name:	Relationship:
Address:	Telephone Number:

If this is a Worker's Compensation, or Auto Accident, Please Complete the Following:

Date of Accident:	Name, Address, and Phone # of Attorney If Attorney is Handling This Case:

If Worker's Comp., Person to Contact to Verify:	Phone:

INSURANCE: Primary	**Secondary:**
COMPANY____	**COMPANY**____
ADDRESS____	**ADDRESS**____
PHONE____	**PHONE**____
EMPLOYER____	**EMPLOYER**____
INSURED'S NAME_______________________________________	**INSURED'S NAME**_______________________________________
GROUP#_________**POLICY#**_____________________________	**GROUP#**_________**POLICY#**_____________________________
ID# (S.S.#)____	**ID# (S.S.#)**____
INSURED'S DATE OF BIRTH_____________________________	**INSURED'S DATE OF BIRTH**_____________________________

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, AT THE TIME OF SERVICE, unless other arrangements are made in advance with the office. I understand and agree that health insurance policies are in arrangement between an insurance carrier and myself. I will take the responsibility for any and all costs incurred by my failure to remit for service rendered. I authorize payment of medical benefits to the physician herein for medical services rendered. A photocopy of this signature is as valid as the original. I also authorize the physician to release any information required in processing of insurance.

Signed ____ Date ________________________

Medical Information Database/Pre-Op Assessment

Name ____ **Date** _________________

Reason for seeing Dr. Wassermann ____
Referring Physician ____
Were you seen in the E.R.? YES NO If YES, which hospital ____________________
Date of accident or injury ____
Primary Care Doctor, Pediatrician, Family Doctor, or GYN, if you have one
____

Previous Medical History

Do you have a latex allergy/Sensitivity? YES/NO
If YES, what type of reaction.____

List all known drug allergies:____
____

List all medications you are taking and the reason (including Aspirin, Ibuprofen, Motrin, NSAID, Goody Powder, Vitamins, Herbal Medications, etc.) Include dose and frequency.
____
____
____
List any medications you cannot take ____
____

Accurate Height and Weight____

Immunizations

Please indicate date (month and year) of last Immunization

Tetanus Booster _________________	Chicken Pox ________________________
DPT ___________________________	Hepatitis B _________________________
MMR __________________________	Polio ______________________________

Current Medical Problems (please X YES or NO)

YES	NO		YES	NO	
____	____	High Blood Pressure	____	____	Cardiac Disease/Heart Attack
____	____	Cancer	____	____	Diabetes
____	____	Immune Deficiency	____	____	Kidney Disease
____	____	Lung Disease	____	____	Substance Abuse
____	____	HIV/AIDS	____	____	Hepatitis A/B/C
____	____	Breast Disease			

If other, please explain ____

Patient Name ____ **Date** _______________

Review of Systems (please X YES or NO)

YES	NO		YES	NO	
____	____	Fever	____	____	Vision Problems
____	____	Sinusitis	____	____	Chest Pain
____	____	Seizures	____	____	Constipation
____	____	Skin lesions that are changing	____	____	Coughing up blood
____	____	Excessive bleeding/easy bruising	____	____	Chills
____	____	Glasses	____	____	Sore Throat
____	____	Shortness of breath	____	____	Weakness/Numbness
____	____	Sleep Apnea	____	____	Reflux
____	____	Diarrhea	____	____	Blood in urine
____	____	Jaundice	____	____	Weight loss or gain
____	____	Ear aches	____	____	Wheezing/asthma
____	____	Heartburn	____	____	Fainting
____	____	Blood in bowel movements	____	____	Difficulty urinating
____	____	Depression or Anxiety	____	____	Difficulty healing

Previous Hospitalizations

Date (month/year)	Reason for Hospitalization
____________________	____
____________________	____
____________________	____
____________________	____

Past Surgical History

Date (month/year)	Procedure	Difficulty with Anesthesia
_______________	________________________	YES NO
_______________	________________________	YES NO
_______________	________________________	YES NO
_______________	________________________	YES NO
_______________	________________________	YES NO
_______________	________________________	YES NO

If medically necessary would you object to a blood transfusion YES NO

Last menstrual period________________ Any chance of being pregnant_____________

Patient Name ________________________________ **Date** __________________

Social History

Do you use tobacco products of any kind? YES NO Amount/Frequency _______

Do you drink alcohol? YES NO Amount/Frequency _____________

Do you use illegal drugs? YES NO Amount/Frequency _______________

Occupation ____

Living Situation (who is in your household) _________________________________
____

Family History

Please X YES or NO and list the relationship

	YES	NO	Relationship
High Blood Pressure	____	____	_________________
Diabetes	____	____	_________________
Breast Cancer	____	____	_________________
Melanoma	____	____	_________________
Other Cancers	____	____	_________________

Date of most recent lab work, EKG, x-ray or diagnostic tests______________________
Location___________________________
Phone_____________________________

Please list the two most important questions we can answer for you at your initial consultation.____
____