

If you are under the age of 18 years old, you will need your Parent or Guardian to sign this paperwork.

PATIENT INFORMATION

Name _____ Date of Birth _____ Age _____
Mailing Address _____ SS# _____ Male/Female _____
City _____ State _____ Zip _____ Married Single Divorced Widowed

May we leave medical information on your answering machine? Y N

Home Phone (____) _____ Cell Phone (____) _____

May we e-mail personal medical information to you? Y N E-mail Address _____

Alternate Address _____ City _____ State _____ Zip _____

Occupation/School/Employer _____ Work Phone (____) _____

Primary Care Physician _____

In case of Emergency, who should be notified _____ Phone (____) _____

Name and Address of person Responsible for the bill:

Relationship to Patient _____

Name _____ Date of Birth _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (____) _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK IN)

I, the undersigned, understand that if I have not provided DCSI with my current insurance card within 45 days from the date of service, I will be responsible for the entire balance due. My insurance will not be filed, and an insurance adjustment will not be made.

Primary	Secondary
Insurance Name _____	Insurance Name _____
Policy Holders Name _____	Policy Holders Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone _____ Date of Birth _____	Phone _____ Date of Birth _____
ID# _____	ID# _____
Relationship of patient to insured _____	Relationship of patient to insured _____

Do you give our office permission to discuss your medical information with family members?

Yes No If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (____) _____ Phone # (evening): (____) _____

Name: _____ Relationship: _____

Phone # (day): (____) _____ Phone # (evening): (____) _____

I authorize the release of medical information to my primary care referring physician, to consultants, if needed and as necessary to process insurance claims, Insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

I, the undersigned, understand that if my account has not been paid in full within 90 days from the time my insurance responds, the account will be referred to our collection agency, Allied Collection Services, Inc., for collection procedures and I am responsible for all cost including fees, attorney fees, and court costs.

The staff of this office pledges to give the finest care our capacities allow. Complications are seldom seen in the many surgical procedures performed, however, it should be understood that even small surgical procedures can scar, occasionally bleed, and rarely become infected or incite allergic response.

X _____
Signature Date

MEDICAL HISTORY

Name _____ Date of Birth _____ Date ____/____/____

Are you Allergic to any medications? No Yes (Please List)

Are you allergic to tape or bandaids? No Yes (Please List) _____

Are you allergic to any numbing medications or dental anesthesia? No Yes (Please List) _____

Please List any other Allergies _____

*PLEASE HAVE YOUR LIST OF MEDICATIONS AVAILABLE FOR THE NURSE WHEN ASKED

Do you or have you ever had diseases or conditions of: (please circle)

Lungs

History of Tuberculosis

Emphysema

Asthma

Chronic Cough

Vascular

High Blood Pressure

Chest Pain

Heart Attack

Heart Murmur

Heart Valve Prolapse

Irregular Heartbeat

Pacemaker / Defibrillator

Phlebitis

Bleeding Disorder

Other Systemic

Alzheimers/Dementia

Diabetes

Thyroid

Kidney

Bladder

Stomach

Bowel

Hepatitis or Jaundice

Glaucoma

Arthritis / Joint Deformity

Convulsions, Epilepsy or Seizures

Fainting

Lupus

Cancer (what type) _____

Fibromyalgia

Sexually Transmitted Disease

Other _____

Please answer the following questions:

Do you drink alcohol? YES NO If YES, _____ drinks per day?

Do you use IV drugs? YES NO If YES, what? _____ How much?

Have you had or have you been exposed to HIV (AIDS)? YES NO

Do you smoke? YES NO If YES, how much?

Are you pregnant? YES NO Due Date: _____

Do you have artificial joint(s)? YES NO

Do you have a Hearing Aid or impaired hearing? YES NO

Are you required to take antibiotics before minor surgery? YES NO

Have you ever had skin cancer? YES NO Type: _____ Location: _____

Has anyone in your family had skin cancer? YES NO If YES, who?

Have you had any skin diseases? YES NO
please list: _____

List type and dates of previous surgeries you have had: _____

What are your hobbies? _____

Signed by Physician _____

Date _____