

Welcome to our office. Please complete and sign this form. If completing this form online, please print to bring to your appointment.

Name _____ Male Female E-mail _____
Last First MI
Phone# _____ Best number to reach you? _____
Home Work Cell
Address _____ City _____ State _____ Zip _____
Social Security # _____ Age _____ Date of Birth _____ Married Single Divorced Widow
Employer _____ Address _____ City _____ State _____ Zip _____
Name of Spouse _____ Spouse Employer _____ Spouse phone # _____
Referred by? _____ Primary Care Physician _____
Emergency contact _____ Phone # _____ Relationship _____

Medical Insurance Information

Primary Ins. Co. _____ Secondary Ins. Co. _____
Subscriber's Name _____ Sub. Name _____
Subscriber's SS # _____ Sub. SS # _____
Subscriber's date of birth _____ Sub. Date of birth _____
Insurance billing address _____

I declare that the above information is true and correct and that I have read and understand the information written above. I hereby authorize Dr. Daniel Bank to provide medical or emergency care to the above named person or myself. I authorize my insurance company to pay benefits directly to Dr. Daniel Bank and also acknowledge that non-covered services are my responsibility.

Signature _____ Date _____

If patient is a MINOR, please complete this section

Name of Mother _____ Name of Father _____
Address (M) _____ Address (F) _____
SS # (M) _____ SS # (F) _____
Home Phone # (M) _____ Home Phone # (F) _____
Work Phone # (M) _____ Work # (F) _____
Employer (M) _____ Employer (F) _____
If patient is a minor, I hereby authorize Dr. Daniel Bank to treat the above named minor for any medical care.
Signature of patient or guardian _____ Date _____

Notice of Privacy Practices I acknowledge that I have been informed of the Notice of Privacy Practices, and that a copy is available upon request.

Signature _____ Date _____

CURRENT PROBLEM: _____
Where?: _____ How long?: _____
Previous treatment (x-rays, medication, other doctors, etc.) : _____

NAME:	DATE:
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MEDICAL HISTORY

ALLERGIES NONE Penicillin Sulfa Codeine Aspirin Tape Latex Iodine Shellfish

Other Medicine, Food Allergies: _____

CURRENT MEDICATIONS include prescriptions, over-the-counter, vitamins, herbals Aspirin Coumadin

ILLNESSES Please answer "yes" or "no" if you have had any of the following or are taking medications for treatment of:

<p>Yes No</p> <input type="checkbox"/> <input type="checkbox"/> Diabetes -How long _____	<p>Yes No</p> <input type="checkbox"/> <input type="checkbox"/> Blood clot in leg (DVT)	<p>Yes No</p> <input type="checkbox"/> <input type="checkbox"/> Murmur
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Muscular dystrophy / disease
<input type="checkbox"/> <input type="checkbox"/> Heart Attack -When _____	<input type="checkbox"/> <input type="checkbox"/> Epilepsy / seizures	<input type="checkbox"/> <input type="checkbox"/> Neuropathy
<input type="checkbox"/> <input type="checkbox"/> Pacemaker	<input type="checkbox"/> <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> <input type="checkbox"/> "Arthritis" (osteoarthritis)
<input type="checkbox"/> <input type="checkbox"/> Stroke (CVA)-When _____	<input type="checkbox"/> <input type="checkbox"/> GERD	<input type="checkbox"/> <input type="checkbox"/> Arthritis, other _____
<input type="checkbox"/> <input type="checkbox"/> Stroke (TIA)-When _____	<input type="checkbox"/> <input type="checkbox"/> GI/Rectal bleeding	<input type="checkbox"/> <input type="checkbox"/> Osteoporosis
<input type="checkbox"/> <input type="checkbox"/> Acid Reflux	<input type="checkbox"/> <input type="checkbox"/> Gout	<input type="checkbox"/> <input type="checkbox"/> Parkinson's
<input type="checkbox"/> <input type="checkbox"/> Allergies, seasonal	<input type="checkbox"/> <input type="checkbox"/> Hearing aid	<input type="checkbox"/> <input type="checkbox"/> Peripheral Arterial or Vascular Disease
<input type="checkbox"/> <input type="checkbox"/> Alzheimer's	<input type="checkbox"/> <input type="checkbox"/> Heart Disease / CAD	<input type="checkbox"/> <input type="checkbox"/> Phlebitis
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Dialysis / Hemodialysis	<input type="checkbox"/> <input type="checkbox"/> Pulmonary Embolus in Lungs
<input type="checkbox"/> <input type="checkbox"/> Angina	<input type="checkbox"/> <input type="checkbox"/> Hepatitis A	<input type="checkbox"/> <input type="checkbox"/> Raynaud's disease
<input type="checkbox"/> <input type="checkbox"/> Anxiety	<input type="checkbox"/> <input type="checkbox"/> Hepatitis B	<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> <input type="checkbox"/> Arrhythmia	<input type="checkbox"/> <input type="checkbox"/> Hepatitis C	<input type="checkbox"/> <input type="checkbox"/> Sciatica
<input type="checkbox"/> <input type="checkbox"/> Artificial heart valves _____	<input type="checkbox"/> <input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell
<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> High cholesterol	<input type="checkbox"/> <input type="checkbox"/> "Slipped Disc"
<input type="checkbox"/> <input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> <input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> <input type="checkbox"/> Tattoos
<input type="checkbox"/> <input type="checkbox"/> Back Problems _____	<input type="checkbox"/> <input type="checkbox"/> Hypothyroid	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease _____	<input type="checkbox"/> <input type="checkbox"/> Ulcers in stomach or intestine
<input type="checkbox"/> <input type="checkbox"/> Cancer -where _____	<input type="checkbox"/> <input type="checkbox"/> Lung Disease _____	<input type="checkbox"/> <input type="checkbox"/> Varicose veins
<input type="checkbox"/> <input type="checkbox"/> COPD	<input type="checkbox"/> <input type="checkbox"/> Lupus / SLE	<input type="checkbox"/> <input type="checkbox"/> Currently pregnant
<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Multiple sclerosis (MS)	<input type="checkbox"/> <input type="checkbox"/>

MAJOR SURGERIES, HOSPITALIZATIONS, INJURIES	SOCIAL HISTORY
	Occupation: _____
	Athletic activities: _____
	Alcohol: <input type="checkbox"/> None _____ ounces per week
	Tobacco: <input type="checkbox"/> None <input type="checkbox"/> Quit _____ packs per day for _____ years
	Drug use: <input type="checkbox"/> None _____

FAMILY HISTORY/WHO?	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Heart Attack _____	<input type="checkbox"/> Cholesterol _____
<input type="checkbox"/> Rheumatoid _____	<input type="checkbox"/> Lupus _____	<input type="checkbox"/> High Blood Pressure _____		

REVIEW OF SYSTEMS Do you currently feel any of the following symptoms?				<input type="checkbox"/> NONE	<input type="checkbox"/> Chills
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Fever	
<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Leg or foot swelling	<input type="checkbox"/> Calf pain when walking	<input type="checkbox"/> Leg cramps at night	<input type="checkbox"/> Cold feet or toes	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> "Poor circulation"	<input type="checkbox"/> Burning in the feet	<input type="checkbox"/> Numbness in the feet	<input type="checkbox"/> Spider veins	