We are looking forward to seeing you in our office in the near future. Enclosed is a packet of information which helps us to prepare for your care. We ask that you have this completed prior to your appointment so we can review it thoroughly. **Please bring your insurance cards**, a **list of all current medications**, and a copy of all recent tests relating to the problem which we are seeing you for if available. (CT, MRI, Ultrasound discs and reports with you). **NOTE**: We will be taking your picture to put in your chart for identification purposes.

Please bring your completed paperwork along with your pharmacy information to your appointment and arrive 15 minutes early so that we can review it with you. If you have an HMO insurance, please check with your primary physician to see if you need an insurance referral. We may need to reschedule your appointment if we do not have your insurance referral at the time of your visit! Your office visit co-payment will be collected at the time of your visit. If we have to bill you for the co-payment there will be a $5.00 processing fee.

Our office is located at 9 Brookwood Avenue, Carlisle PA 17015

Thank you for taking the time to prepare for your visit. If you have any questions or if you cannot keep your appointment, please to call us at **(717) 243-0616.**

The office may choose to bill a $50.00 charge for appointments that are not cancelled within 24 hours. The office may choose not to reschedule you if you do not show up for your appointment along with a 50.00 no show fee.

PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW:

DEMOGRAPHIC INFORMATION:

Name: ___________________________________ Today's Date: ___________________________

Date of Birth: ____________________________ Sex: Male or Female

Address: ____

City: _________________________ State: ____________________ Zip code: __________

Home#: _______________________ Work#: __________________ Cell#: ______________

Email Address: ____

Emergency Contact: ________________________ **Phone#**_______________________________

Relation: ____

Primary Pharmacy: ____

Mail Order Pharmacy: ____

Race: (circle one)

American Indian/Alaskan Native

Asian

African American/Black

Native Hawaiian / Other Pacific Islander

Caucasian/White

Refused

Ethnicity (circle one)

Not Hispanic / Latino

Non-Hispanic African

Refused

Primary Language: ____

PRIMARY INSURANCE INFORMATION:

Insurance Name: _________________________________ ID#______________________

Subscriber's Name: ________________________________ Subscriber DOB___________

SECONDARY INSURANCE INFORMATION:

Insurance Name: ____________________________ ID#_________________________

Subscriber's Name: __________________________ Subscriber DOB_______________

Patient Name:___________________________ **Date of Birth:**_______________

NEW PATIENT MEDICAL HISTORY FORM:

Preferred Name: ____________________________________ Date: ____________________

What Pharmacy do you use? ____

Were you referred to our office? Yes or No

If yes, by whom? ____

Review of Medical Symptoms:

At this time do you have any following complaints?

Please answer Yes or No

Constitutional: Fatigue___________ Weight Change ___________ Fever ____________

Eyes: (Y/N) ______

Ear/Nose/Throat (Y/N) ____

Cardiovascular: (Y/N) ____

Skin: (Y/N) ____

Respiratory: (Y/N) ____

Neurologic (Y/N) ____

Gastrointestinal: (Y/N) ____

Psychiatric (Y/N) ____

Genitourinary: (Y/N) ____

Endocrine (Y/N) ____

Musculoskeletal (Y/N) ____

Allergies (Y/N) ____

Heme/Lymphatic (Y/N) ____

Medical Allergies:

Do you have a Latex Allergy? (Yes or No) __________________

Please list all known allergies to medications and your reaction. If none, state N/A:

____

____

____

Patient Name: ______________________________ **Date of Birth**: _______________________

Have you ever had any complications with Anesthesia? (Yes or No) ________

(If yes, what?)____

Do you have difficulty stopping bleeding or do you have a bleeding disorder (Y/N) _________

Family Medical History:

Does any member of your immediate family (Parents/Siblings/Children) have or have ever been treated for the following: yes or no (if Yes) Whom?

Bleeding Disorder____

Complication with Anesthesia____

High Blood Pressure____

Asthma/Emphysema____

Heart Disease____

Cancer :(Type, Date, Treatment)

____

Other: ____

Social History: You're Age: ____________

Marital Status: single married divorced widowed Number of Children: _______

Who lives at home with you? ____

Your Employer: _______________________ (retired) previous Employer: _________________________

Occupation-Position held:____

Do you or have you ever used: Cigarettes _______ Cigars _______ Tobacco_________

Amount per day: ____________ Years: _______________ Years since you quit: ______________

Do you drink Alcohol? ____________________________

Drinks per day: _____________ Type: ___________________

Do you or have you ever abused drugs? Y/N Type: ___________________

Patient Name_______________________ **Date of Birth: _____________________**

Medical History:

Have you ever been hospitalized? (Reason?)

____

____

Please list any current or past medical conditions you have been diagnosed with:
____

____

Have you ever been diagnosed with cancer? (If so what type)

____

____

Have you ever been diagnosed with HIV / Hepatitis /Etc. (Y/N) if Yes, what type?

____

Past Surgical History:

Have you ever had surgery? (What type?)

____

____

____

Have you ever had any procedures or surgeries for your heart?

____

____

____

Patient Name: ____________________________ Date of Birth: ___________________________

Have you ever had any complications with surgery? (Y/N) _____ If yes, what

____

Medications:

Please list all medication that you currently take including vitamins and non-prescription of alternative medications, the dosage and frequency. If none, please state N/A:

____

____

____

____

____

____

____

____