

NEW PATIENT INFORMATION

Patient's Name _____ Home Phone () _____

Cell () _____ Email _____

May we leave a message regarding your medical care to the numbers above? __yes __no

Address: _____ Social Security No. _____

City _____ State _____ Zip code _____

Date of birth _____ Age _____ Sex _____ Marital Status _____

Employed By: _____ Phone () _____

Address: _____

Occupation: _____ **May we leave a message at this work number? __yes __no**

Emergency Contact Person _____ Phone () _____

May we leave a message with this person regarding your medical care? __yes __no

Address: _____

Primary Care Physician _____ Phone () _____

Referred by _____

Brief Reason for today's visit _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand that payment is due at the time of service. I hereby authorize the release to my insurance carriers of any and all information necessary to process insurance payments for medical services rendered to myself or my dependents and I hereby assign to the physician all payments. I understand that I am responsible for any amount not covered by insurance or authorized third party payer. This agreement shall be in effect for the duration of this and any other treatments that shall be rendered to me or my dependents by Greg Morrison, M.D.

Your signature below also indicates that you have been advised of our HIPAA compliance and that you may upon request receive a personal written copy of our Notice of Privacy Practices.

Signature _____

Date _____

History Intake Form

Patient Name: _____ Birth Date _____

Please answer all the questions as accurately as possible. If you do not understand the question please ask for assistance.

Primary Care Doctor: _____

Smoking -Yes ___ No___(type & amount per day) _____ Alcohol (type and amount per week) _____
If former smoker, date quit: _____ Weight _____ Height _____

Drug Allergies: _____

List previous surgeries or major illnesses and dates: _____

List any medications you are taking, including non-prescription drugs, vitamins, and herbals: _____

Latex Allergy: _____ Yes _____ No

Family History:

Has any blood relative ever had the following:

Breast Cancer.....	No	Yes	High Blood pressure....	No	Yes	Kidney disease.....	No	Yes
Melanoma	No	Yes	Heart Disease.....	No	Yes	Depression.....	No	Yes
Stroke.....	No	Yes	Diabetes.....	No	Yes	Bad reaction to anesthesia	No	Yes

Past Medical History

Have you ever had the following:

Heart disease.....	No	Yes	Cancer	No	Yes	Stomach Ulcer.....	No	Yes
Arthritis.....	No	Yes	Glaucoma.....	No	Yes	Kidney disease.....	No	Yes
Rheumatic Fever.....	No	Yes	Asthma.....	No	Yes	Thyroid disease.....	No	Yes
Anemia.....	No	Yes	AIDS or HIV+.....	No	Yes	Bleeding tendency.....	No	Yes
Tuberculosis.....	No	Yes	Stroke.....	No	Yes	Mitral valve prolapse.....	No	Yes
Diabetes.....	No	Yes	Hepatitis.....	No	Yes	High blood pressure.....	No	Yes

Review of Systems

Do you have now or have you had within the past year:

Weight Change.....	No	Yes	Swollen feet/ankles....	No	Yes	Seizures.....	No	Yes
Dry eyes.....	No	Yes	Skin rash.....	No	Yes	Joint or muscle pain.....	No	Yes
Chronic cough.....	No	Yes	Chronic diarrhea.....	No	Yes	Swollen lymph nodes.....	No	Yes
Chest pain.....	No	Yes	Jaundice.....	No	Yes	Easy bleeding.....	No	Yes
Rapid heart beat.....	No	Yes	Depression.....	No	Yes	Easy bruising.....	No	Yes
			Bad reaction to anesthesia	No	Yes	Abnormal chest x-ray.....	No	Yes

Women only:

Date of last mammogram _____

Do you do regular breast self-examinations? No Yes

Are you pregnant? _____

Did you breast feed? No Yes

Breast lump or discharge No Yes

Additional comments on known/previous medical problems _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X _____

Signature of patient or parent if minor

Date