

Patient Information

Please print and answer all questions completely. If any of this information changes in the future, please let the office know. Thank you.

Patient Name _____ Today's Date _____

Street Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Social Security # _____ Sex ___M ___F

Phone Numbers: Home # _____ Office # _____ Cell # _____

E-mail Address _____ Marital Status _____ Preferred Phone #: ☐home ☐cell

Emergency Contact _____ Relationship to Patient _____ Phone _____

Who is your Primary Care Doctor? _____ Phone # _____

How did you find out about our practice? ☐ Internet ☐ friend _____ ☐ other

If other, please explain: _____

Are you employed? ___ Yes ___ No What is your usual occupation? _____

Pharmacy Name _____ Pharmacy Phone _____

INSURANCE INFORMATION (if applicable)

Insurance 1 _____ Policy Holder _____ Social Security # _____

Policy # _____ Group # _____ Copay Amount _____

Employer responsible for insurance: _____ Phone _____

Address: _____

Do you have additional (secondary) insurance? Insurance 2: _____ Policy Holder _____

Policy # _____ Group # _____

GUARANTOR INFORMATION

(The guarantor is the person responsible for the patient's finances: for example, parent, spouse or the actual patient.)

Is the guarantor the patient? ___ Yes ___ No (If no, please fill in the information below for the Guarantor.)

Name _____ Relationship to Patient _____

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Birthdate _____ Phone: (W) _____ (H) _____

I authorize release of any medical information necessary to process any insurance claims. I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances, or amounts for services not covered by the insurance carrier. I also understand that it is my responsibility to obtain the necessary referrals for my visits and medical care, and to verify that my insurance is active and up to date. I also give consent to the taking of photographs for the medical record or teaching purposes, as long as the identity of the patient is not revealed. This authority shall remain outstanding until withdrawn in writing by the undersigned.

Signature _____ **Date** _____
(Patient or Guardian)

MEDICAL INFORMATION

Why have you come to see Dr. Raskin? _____

Height _____ Weight _____

List all **ALLERGIES**/reactions to medications

List all **MEDICATIONS** taken on a regular basis

Aspirin ___ Pain Medication ___ Blood Thinner ___ Insulin ___ Anti-inflammatory (Advil) ___ Vitamin E _____

Have you ever taken **STEROIDS**? ___ Yes ___ No type: _____

Have you ever **SMOKED**? ___ Yes ___ No What _____? How much? _____ Quit Date _____

Do you drink **ALCOHOL**? ___ Yes ___ No How much _____ How often _____ Quit Date _____

List medical problems you have or have had in the past _____

Please list all surgeries you have had and when they took place: _____

Have you ever had a problem with anesthesia? ___ Yes ___ No. If yes, describe _____

Number of pregnancies _____ Age at last pregnancy _____ Have you had a C-Section? ___ Yes ___ No

Please check any of the following which you have or have had in the past:

___ High Blood Pressure	___ Chest Pain	___ Connective Tissue Disease	___ Cold Sore
___ Heart Attack	___ Tuberculosis	___ Shortness of Breath	___ Skin Cancer
___ Arrhythmia	___ Liver Disease	___ Chemical Peel/Retin A	___ Ulcers
___ Blood Clot	___ Thyroid Disorder	___ Unexplained weight loss	___ Stroke
___ Diabetes	___ Night Sweats	___ Keloid/Hypertrophic scar	___ Arthritis
___ Joint Replacement	___ Rheumatic Fever	___ Reynaud's Disease	___ Psychiatric
___ Heart Valve Problem	___ Bone/Joint Disease	___ Skin Rash or Problem	___ Gout
___ Nerve Problem	___ Cancer	___ Hepatitis	___ Transfusion
___ Aids or HIV+	___ Herpes/Zoster	___ Bruise easily; gums bleeding	

Circle if your relatives are alive (A) or deceased (D) and list any medical problems they had:

Mother (A/D) _____

Father (A/D) _____

Children (A/D) _____

Brothers (A/D) _____

Sisters (A/D) _____

Aunts (A/D) _____

Uncles (A/D) _____

Maternal Grandmother (A/D) _____

Maternal Grandfather (A/D) _____

Paternal Grandmother (A/D) _____

Paternal Grandfather (A/D) _____