



Name _____ SS# _____

Street Address _____ Date of birth _____ Marital status: S M W Sep D

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Referred by _____

Spouse's name _____

Spouse's employer / address _____

Emergency contact _____ Tel# _____ Relationship _____

PATIENT EMPLOYER INFORMATION

Employer name _____ Tel# _____

Employer street address _____ City / State _____ Zip _____

Patients occupation _____

INSURED PERSON (IF NOT PATIENT)

Name _____ Tel# _____

Street Address _____ City / State _____ Zip _____

Relationship to patient _____

INSURANCE

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

Secondary Insurance Company Name _____

ID # _____ Group # _____ Tel.# _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. Pampe _____ to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. Pampe _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____

(Patient, parent, or guardian)

MISCELLANEOUS NOTES



Name _____ SS# _____ Date _____
 Address _____ Occupation _____
 Phone (home) _____ (work) _____ Date of birth _____ Age _____
 Chief complaint _____

DRUG ALLERGIES

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDS

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

- | | | |
|------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Lactose intolerance _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Gallbladder disease _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Heart palpitations _____ | <input type="checkbox"/> Prostate disease _____ | <input type="checkbox"/> Scarlet fever _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Bowel irregularity _____ | <input type="checkbox"/> Chronic rashes _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Incontinence _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Dizziness/Fainting _____ | <input type="checkbox"/> Sexual/menstrual dysfunction _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Peripheral vascular disease _____ | <input type="checkbox"/> Venereal disease _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI disorder _____ | <input type="checkbox"/> Nervousness _____ | <input type="checkbox"/> Other _____ |

WOMEN ONLY: Pregnant? Yes No Planning pregnancy? Yes No
MEN ONLY: It's common for men to occasionally experience erection difficulties. Is this something that happens to you? Yes No
 How often does this occur? Frequently Sometimes Rarely

HABITS

- | | | |
|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Smoke: Packs daily _____
How long? _____
Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups daily _____
Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____ |
| <input type="checkbox"/> Exercise routine: _____ | <input type="checkbox"/> Alcohol: Type _____
Amount _____ | |
| | <input type="checkbox"/> Diet: Salt intake _____
Fat intake _____ | |

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I'm looking within

LIPITOR
atorvastatin calcium tablets

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