Patient Medical Form

General / Family Practice

Please print clearly and complete all sections.

SECTION 1: PATIENT DEMOGRAPHICS

Full Legal Name (Last, First, Middle): _____

Preferred Name: _____ Date of Birth (MM/DD/YYYY): _____

Sex: M / F / Other _____ Age: _____ Marital Status: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Phone (Primary): _____ Phone (Alternate): _____

Email Address: _____ Preferred Contact Method: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

SECTION 2: INSURANCE INFORMATION

Primary Insurance Company: _____ Policy/Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance (if any): _____ Policy/Group #: _____

SECTION 3: MEDICAL HISTORY

Check all conditions that apply to you now or in the past:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Asthma/COPD

☐ Stroke ☐ Cancer (type: ____) ☐ Thyroid Disorder ☐ Kidney Disease

☐ Seizures/Epilepsy ☐ Liver Disease ☐ Arthritis ☐ Depression/Anxiety

☐ Bleeding Disorder ☐ Anemia ☐ GERD/Acid Reflux ☐ Sleep Apnea

Other Conditions: _____

Previous Surgeries / Hospitalizations (include year): _____

SECTION 4: CURRENT MEDICATIONS

List all prescription medications, over-the-counter drugs, vitamins, and supplements:

Medication Name	Dose / Strength	Frequency	Reason

SECTION 5: ALLERGIES

☐ No Known Allergies

If you have allergies, list each one with the reaction you experienced:

Allergy (Drug / Food / Environmental)	Reaction

SECTION 6: REASON FOR TODAY'S VISIT

Primary Reason / Chief Complaint: _____

_____

When did symptoms begin? _____

Pain Level (circle one): 0 1 2 3 4 5 6 7 8 9 10

SECTION 7: CONSENT & SIGNATURE

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I authorize this practice to release medical information as necessary for treatment, payment, or healthcare operations. I understand that I am financially responsible for any charges not covered by my insurance.

Patient Signature: _____ Date: _____

Printed Name: _____ Relationship (if signed by representative): _____