Atlantic
Medicine & Wellness

2399 Route 34 Suite A-5 Wall Township, NJ 08736
Phone: (732) 528-5533 Fax: (732) 528-0360

PATIENT PERSONAL HISTORY FORM

NAME: _____
(PLEASE PRINT)
D.O.B.: ___/___/____
Birth Place: _____
Primary Care Physician: _____
Phone Number: _____
Date of Last Physical:_____/___/_____
List all States and Countries in which you have lived in:
_____ _____ _____
_____ _____ _____

Chief Complaints: (List all symptoms)

1.	2.
3.	4.

Personal History:

Do you Smoke?	No	Yes
Do you Drink?	No	Yes
Beer	No	Yes
Wine	No	Yes
Coffee	No	Yes_____cups/day
Decaffeinated	No	Yes_____cups/day
Tea	No	Yes_____cups/day
Herbal Tea	No	Yes_____cups/day
Juice	No	Yes_____cups/day
Milk	No	Yes_____cups/day
Water	No	Yes_____cups/day
Pop	No	Yes_____cups/day

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Are you on a special diet? (If so, please describe)

_____

_____

X-Rays: Have you had any of these X-RAYS, MRI's, or CAT SCANS in the past year? If so, when?

Chest	No	Yes/When:
Stomach	No	Yes/When:
Colon	No	Yes/When:
Gall Bladder	No	Yes/When:
Back/Neck	No	Yes/When:
Kidney	No	Yes/When:
Extremities	No	Yes/When:
Other:	No	Yes/When:

Immunizations: Have you ever been immunized again:

Small Pox	No	Yes/When:
Tetanus	No	Yes/When:
Polio (shots or oral)	No	Yes/When:
Measles	No	Yes/When:
German Measles	No	Yes/When:
Other	No	Yes/When:

Allergies: Are you allergic to the following?

Penicillin	No	Yes
Sulfa	No	Yes
Other Antibiotics	No	Yes
Any other drug/medicine	No	Yes
Any Food	No	Yes
Nail Polish/Cosmetics	No	Yes
Other		

Weight Loss/Sleep Disorders:

Have you gained weight in the last year? If so, how much? _____

Have you lost weight in the last year? If so, how much? _____

Do you have trouble falling asleep? _____

Do you have trouble staying asleep? _____

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Medicine:

Please list all prescription medicines or drugs you are currently taking, that were prescribed by a Doctor or Dentist. (Include what you take for chronic conditions, birth control, etc.).
*Please indicate strength and quantity taken daily.

1.	2.
3.	4.
5.	6.

Please list over the counter medicines or drugs you may take without a prescription.
(Aspirin, antacids, sleep medicine, etc.)

1.	2.
3.	4.

Please list all vitamins, minerals and/or nutritional supplements that you are now taking.
*Please indicate strength and number taken daily.

1.	2.
3.	4.
5.	6.

Devices: Do you use:

Eyeglasses	No	Yes
Contact Lenses	No	Yes
Hearing Aid	No	Yes
Dentures	No	Yes
Neck Brace	No	Yes
Back Brace	No	Yes
Other Brace	No	Yes
Artificial Limb	No	Yes
Pacemaker	No	Yes
I.U.D.	No	Yes
Diaphragm	No	Yes

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Operations: Have you had any of these operated on?

Tonsils	No	Yes/When:
Appendix	No	Yes/When:
Gall Bladder	No	Yes/When:
Stomach	No	Yes/When:
Small Intestines	No	Yes/When:
Kidney	No	Yes/When:
Colon	No	Yes/When:
Thyroid	No	Yes/When:
Hernia (Rupture)	No	Yes/When:
Angioplasty Bi-Pass	No	Yes/When:
Breast	No	Yes/When:
Uterus	No	Yes/When:
Ovaries	No	Yes/When:
Prostate	No	Yes/When:
Other		

Diagnosed Difficulties: Do you now, or have you in the past had any of the following…

Migraine Headaches	No	Past/When:	Yes/Now
Epilepsy/Convulsions	No	Past/When:	Yes/Now
Stroke	No	Past/When:	Yes/Now
Glaucoma	No	Past/When:	Yes/Now
Cataracts	No	Past/When:	Yes/Now
Blindness	No	Past/When:	Yes/Now
Ear Infections	No	Past/When:	Yes/Now
Deafness	No	Past/When:	Yes/Now
Asthma	No	Past/When:	Yes/Now
Hay Fever	No	Past/When:	Yes/Now
Chronic Bronchitis	No	Past/When:	Yes/Now
Emphysema	No	Past/When:	Yes/Now
Tuberculosis	No	Past/When:	Yes/Now
Other			

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Family History: Has any blood relative ever had: (Please answer the following questions by circling "yes" or "no". Fill in the "who" or "when" information when necessary)

Cancer (including Leukemia)	No	Yes/Who:
Tuberculosis	No	Yes/Who:
Diabetes	No	Yes/Who:
Heart Trouble	No	Yes/Who:
Heart Attack	No	Yes/Who:
High Blood Pressure	No	Yes/Who:
Stroke	No	Yes/Who:
Epilepsy	No	Yes/Who:
Bleeding Disorder	No	Yes/Who:
Asthma	No	Yes/Who:
Allergies	No	Yes/Who:
Liver Disease	No	Yes/Who:
Migraine Headaches	No	Yes/Who:
Alcoholism	No	Yes/Who:
Emphysema	No	Yes/Who:
Stomach/Duodenal Ulcer	No	Yes/Who:
Kidney Disease	No	Yes/Who:
Glaucoma	No	Yes/Who:
Sickle Cell Anemia	No	Yes/Who:
Other Anemia	No	Yes/Who:
Mental Illness	No	Yes/Who:
Suicide	No	Yes/Who:
Birth Defects	No	Yes/Who:
Other Serious Disease	No	Yes/Who:

	Living	Dead	Age at Death	Cause of Death
Father				
Mother				
Siblings				
Spouse				
Children				

NAME:_____DOB:____/_ /_____DATE:____/_ /____

QUESTIONNAIRE AND SCORE SHEET

This questionnaire is designed for adults. It lists the factors in your medical history which may promote the growth of *Candida Albicans* (Section A), and symptoms commonly found in individuals who may have problems with abnormal carbohydrate metabolism, multiple allergies and/or the toxic influence of mercury from silver fillings in the teeth (Section B, C, and D). For each "Yes" answer in Section A, circle the point score in that section. Total your score and record it in the box at the end of the section. Then move onto Section B, C, and D and score as directed. Filling out and scoring this questionnaire will help you and your physician evaluate your health problems. Yet will not provide an automatic "Yes or No" answer for any conditions.

SECTION A: HISTORY	**SCORE**
Have you taken tetracyclines for acne for 2 months or longer?	25
Have you any time in your life, taken other "broad spectrum" antibiotics for respiratory, urinary or other infections for 2 months or longer, or in shorter courses 5 or more times in a 1 year period?	20
Have you taken Prednisone, Decadron or other cortisone-type drugs … For more than 2 weeks?	15
For 2 weeks or less?	6
Does exposure to perfumes, insecticides, fabric shop orders and other chemicals provoke… Moderate to severe symptoms?	20
Mild Symptom?	10
Are your symptoms worse on damp, muggy days or in moldy places?	20
Have you had persistent athlete's foot, dandruff or other chronic fungus infections of the skins or nails?	20

FEMALE PATIENTS ONLY

Have you, at any time in your life, been troubled by persistent vaginal problems Episodes of vaginitis in a year	25
Have you been pregnant? YES / NO	
2 or more times?	10
1 time?	5
Have you taken birth control pills? YES / NO	
For more than 2 years	15
For 6 months to 2 years	8
Vaginal Discharge	10
Vaginal burning or itching	5
Endometriosis	10
Pain with period	10
Premenstrual tension	10
TOTAL SCORE SECTION A	

Are These Currently Occurring? YES / NO

NAME:_____DOB:____/_ /_____DATE:____/_ /____

SECTION B: MAJOR COMPLAINTS

For each symptom which is present, enter the appropriate figure in the Point Score column:

If there are no symptoms……. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate..…….. Score 4 points.
If a symptom is severe or disabling……. Score 6 points.

Add total score for this section and record it in the box at the end of the section. Note: If you do not have the symptom, leave blank.

	SCORE
DO YOU CRAVE SUGAR?	
DO YOU CRAVE BREAD?	
DO YOU CRAVE ALCOHOLIC BEVERAGES?	
DO YOU CRAVE CHOCOLATE?	
DOES TOBACCO SMOKE BOTHER YOU?	
FATIGUE OR LETHARGY	
FEELING OF BEING "DRAINED"	
FEELING OF BEING EXHAUSTED	
POOR MEMORY	
FEELING "SPACEY" OR "UNREAL"	
DEPRESSION	
SUICIDAL THOUGHTS	
NUMBNESS, BURNING OR TINGLING	
PAIN AND/OR SWELLING IN JOINTS	
ABDOMINAL PAIN	
CONSTIPATION	
DIARRHEA	
BLOATING	
LOST OF INTEREST IN SEX	
SPOTS IN FRONT OF EYES	
BLURRED VISION	
TOTAL SCORE SECTION B:	

NAME:_____DOB:____/_ /_____DATE:____/_ /____

SECTION C: ADDITIONAL COMPLAINTS

(Same scoring as Section B)

If there are no symptoms…….. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate…….. Score 4 points.
If a symptom is severe or disabling…… Score 6 points.

*Add total score for this section and record it in the box at the end of this section.

	SCORE
Cry easily	
Crying spells	
Nervous Breakdown	
Constant worries	
Anxiety	
Phobias	
Fainting Spells	
Speech Difficulty	
Tremors	
Cold Sweats	
Inside Trembling	
Staggering	
Convulsions	
Nausea	
Oily Hair	
Allergies	
Easy Bruising	
Chills	
Fever	
Swollen Gland	
Nose Bleeds	
Sinus Trouble	
Mouth Problems	
Tongue Problems	
Tooth Problems	
Root Canals	
Silver Amalgam	
Hoarseness	
Rash	
Yellow Skin	
Changing Mole	
Stiff Neck	
Neck Pain	
Wheezing	
Poor Exercise Tolerance	

NAME:_____DOB:____/_ /_____DATE:____/_ /____

If there are no symptoms…….. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate…….. Score 4 points.
If a symptom is severe or disabling…… Score 6 points.

	SCORE
Heart Pounding	
Heart Flutter	
Fast Heart Beat	
Chest Pain	
Frequent Cough	
Night Sweats	
Swollen Ankle	
Pain on urination	
Up to urinate at night	
Urinary Incontinence	
Urinary Frequency	
Urinary Urgency	
Burning Urination	
Back Pain	
Leg Cramps	
Cold	
Too Warm	
Thirsty	
Difficulty Swallowing	

MALE PATIENTS ONLY	**SCORE**	**FEMALE PATIENTS ONLY**	**SCORE**
Difficulty having erections		Breast Lumps	
Lump in Testicle		Discharge from Nipple	
Sore on Penis		Vaginal Spotting	
Discharge from Penis		Hot Flashes	
Breast Lump		Pain with Intercourse	
Impotence		Pelvic Pain	
TOTAL SCORE SECTION C:		**TOTAL SCORE SECTION C:**	

NAME:_____DOB:____/_ /_____DATE:____/_ /____

If there are no symptoms…….. Score 0 points
If a symptom is mild …… Score 2 points.
If a symptoms is moderate…….. Score 4 points.
If a symptom is severe or disabling…… Score 6 points.

SECTION D: OTHER SYMPTOMS

*Add total score for this section and record it in the box at the end of this section.

	SCORE
Jitteriness	
Irritability	
Incoordination	
Inability to Concentrate	
Frequent Mood Swings	
Headache	
Dizziness/Loss of Balance	
Pressure above Ears	
Itching	
Other Rashes	
Heartburn	
Indigestion	
Belching	
Intestinal Gas	
Mucous in Stool	
Hemorrhoids	
Dry Mouth	
Rash or blisters in mouth	
Bad Breath	
Joint swelling or Arthritis	
Nasal Congestion	
Nasal Discharge	
Postnasal Drip	
Nasal Itching	
Sore or Dry Throat	
Cough	
Pain or tightness in Chest	
Wheezing	
Shortness of Breath	
Failing Vision	
Burning or tearing of eyes	
Recurrent ear infections	
Fluid in Ears	
Ear Pain	
Wax in Ears	
Deafness	
Tubes in Ears	
Drowsiness	
Insomnia	
Nightmares	
TOTAL SCORE SECTION D:	

*While the symptoms in this section occur commonly in patients with yeast-connected illness, they also occur commonly in patients who have allergies, chronic viral infections (i.e. Mononucleosis, Cytomegalovirus, Epstein Barr) mercury toxicity from fillings in the teeth, diabetes, low blood sugar and chronic fatigue syndrome.

NAME:_____DOB:____/_ /_____DATE:____/_ /____

Total score from Section A: _____

Total score from Section B: _____

Total score from Section C: _____

Total score from Section D: _____

GRAND TOTAL SCORE (Add up total scores from Section A, B, C and D:

_____

Atlantic Medicine & Wellness

PATIENT INFORMATION (Please Print) 2018

Patient's Last Name		First		Middle
❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. ❑ _____	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Unknown	Birth Date / /	Age	❑ Male ❑ Female
Spouse's Name	Children ❑ No ❑ Yes	# ____	Other family members seen here at AMW	
Street Address		Social Security # -- --		Home Phone ( )
City	State	Zip Code		Cell Phone ( )
Occupation	Employer	Work Address		Work Phone ( )
Employment Status ❑ Full Time ❑Part Time ❑ Not Employed ❑ On Active Mil Duty ❑ Retired ❑ Self Employed ❑ Unknown				
Primary Care Physician	Address		Phone #( )	
Emergency Contact Name	Phone #( )		Relationship	
Referred by				
Email Address				

INSURANCE INFORMATION

Name of Insured	Birth Date / /	Address (if different)	Home Phone ( )
Occupation	Employer	Work Address	Work Phone ( )
Insurance Co	Insured's SS # - -	Policy #	Group #
Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of **secondary** insurance (if applicable)	Insured's Name	Policy #	Group #
Patient's relationship to insured ❑ Self ❑ Spouse ❑ Child ❑ Other		Insured's SS#	Insured's DOB

This information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Atlantic Medicine and Wellness, LLC. I understand that I am financially responsible for any balance. I also authorize AMW, LLC or insurance company to release any information required to process my claims.

☐ Thank you for giving AMW permission to send you our newsletters, informational e-mails and promotions. AMW shall never share your email address with anyone outside the company without your permission. If you do NOT wish to receive our newsletters and other emails please check the box. Also, if at any point, you wish to unsubscribe, please contact the front desk.

Patient/Guardian Signature_____ **Date** _____

Atlantic
Medicine & Wellness

2018 IMPORTANT FINANCIAL UPDATE

Making your way through the tightly regulated health system is difficult, especially in these dynamic times. Our belief is that a strong patient-provider relationship overcomes even the most challenging hurdles. To best serve your needs we appreciate your help with: 1) verifying your personal information; 2) knowing your insurance coverage benefits; and 3) ensuring that your payments are prompt.

Verify Your Personal Information
On your first visit in 2018, we will ask you to verify or provide: 1) your personal information; 2) complete and updated insurance information; and 3) updated photo identification. Please note it is critical to inform AMW about any insurance changes or changes to your personal information, as they may occur throughout the year.

Know Your Insurance Benefits
The rising cost of health care may cause employers to change your benefits packages. As a result, your insurance card may continue to look the same but the benefits may be very different. As a courtesy to you, AMW verifies your benefits and the extent of your coverage. Please note that we are a participating provider in Medicare and that for most other carriers, we accept your insurance as an out-of-network provider. This means that your insurance company will often send the payment for our services to you directly, instead of to us, along with a list of the services we rendered called an EOB (Explanation of Benefits).

Make Prompt Payments
When you receive a check for services rendered at AMW, please mail it or bring into our offices **promptly upon receipt** along with any documentation you receive. Your prompt payment helps us to continue providing services to you and helps you avoid additional charges. Often, AMW will not be your only provider - other providers may be listed on the EOB. Even if other providers or facilities are listed, AMW must obtain a copy of the entire EOB, including payments due to AMW. In such an instance, AMW offers four convenient payment options:

1. Endorse the insurance check sent to you and forward it to our office;
2. Write a personal check for the amount due AMW;
3. Pay with a credit card; or
4. Pay with cash.

Past Due Accounts; Returned Checks

In the event of any past due accounts, please be advised that AMW will avail itself of all remedies available at law and in equity, including, but not limited to dismissal from the practice and/or transferring unpaid balances to a collection agency for payment. In such an event, I agree to pay all attorney's fees, court costs, and all collections costs, up to 50% to the amount owed, which may be assessed by any collection agency retained to pursue the matter. In the event any check is returned to us as unpaid, we will charge a $25.00 fee.

By signing this Important Financial Update, I acknowledge that I have read and understood the foregoing notice. In 2018, AMW hopes you will continue to achieve your optimal wellness. For further questions or assistance, please do not hesitate to contact our Accounts Management team at (732) 528-5533.

Print Name: _____ **Signature:** _____

DOB: _____ **Date:** _____

Atlantic
Medicine & Wellness

2018 DISCLOSURE REGARDING HEALTH CARE SERVICES

The medical doctors of Atlantic Medicine and Wellness, LLC, ("AMW") are dedicated to providing the highest quality medical services to our patients in a unique multidisciplinary office setting. Given this unique setting, AMW differs from the traditional primary care medical practice in the following ways:

1. The medical services provided by AMW are exclusively office based. What this means is that the medical doctors of AMW only provide medical services to patients at the office of AMW during scheduled hours. **We do not provide services at a hospital nor do we provide emergency care.**

2. As AMW does not provide emergency care, calls made to the medical doctors of AMW after office hours will be forwarded to a voice messaging system as opposed to a physician answering service. If you experience a medical emergency, please call 911 and/or seek immediate treatment at the hospital or urgent care center nearest to you.

3. The medical doctors of AMW are dedicated to working in collaboration with the other primary care and specialist physicians involved in your care. As such, the medical doctors of AMW strongly recommend that you maintain a doctor-patient relationship with one or more physicians appropriate to your condition and/or situation even while seeking care at AMW.

4. Based on your condition, the medical doctors of AMW may refer you to one or more of the closely allied licensed health care professionals employed or engaged by AMW. These professionals include chiropractic physicians, physical therapists, nutritionist, acupuncturist, mental health counselor, massage therapist, etc.

5. Based on your medical condition, the doctors of AMW may order or perform certain diagnostic tests or studies. In order to maximize the effectiveness of your care, it is imperative that you schedule and honor a necessary follow up appointment with the medical doctor who ordered or performed the diagnostic test or study to both go over the results of the test and to adjust your plan of care accordingly.

By signing this Disclosure Regarding Medical Services, I acknowledge that I have read and understood the foregoing notice.

Print Name: _____ **Signature:** _____

DOB: _____ **Date:** _____

2018 CONSENT FOR TREATMENT AND DISCLOSURE OF PATIENT INFORMATION

I hereby authorize ATLANTIC MEDICINE & WELLNESS, LLC ("AMW") to perform the treatments and/or procedures advised by my provider. I acknowledge that no guarantees, either implied or expressed, have been made to me regarding the outcome of such treatments and/or procedures, as I fully understand it is impossible to make guarantees regarding such outcomes.

I hereby further acknowledge and understand that the providers and medical staff of AMW shall explain to me the potential risks, benefits and alternatives of these treatments and/or procedures and shall outline and discuss the goals of my treatment plan and review the treatment options with me.

I hereby further acknowledge and understand that from time to time AMW may inform me of new treatments or other services that may be appropriate for my condition and/or from time to time may inform me of new services that may be appropriate for a person in my situation (age, sex, etc.) I consent to the use of my identifiable patient information to notify me of such new treatments, or other services that may be necessary for the continuity of my care or which may be of benefit in maintaining or improving my health, with the understanding that AMW will not provide such information to others for marketing, fund-raising, or similar purposes without my specific consent.

The Privacy Rule that is contained in the *Health Insurance Portability and Accountability Act Of 1996* ("HIPAA") establishes a federal requirement that health care providers must obtain a patient's written consent before using or disclosing the patient's personal health information to carry out any treatment, payment, or health care. This consent must be obtained before information may be used or disclosed, except in emergency situations.

I hereby acknowledge and understand that by giving consent I am permitting my personal health information to be disclosed to persons who will be involved in my treatment; it may also be used for payment and operational purposes. AMW reserves the right to change the terms of the notice of privacy practices; such changes in the privacy practices shall be made available to me. I may request additional restrictions on access to this information for treatment, payment or health care. I hereby acknowledge and understand that AMW may not be able to comply with this request. I request the following special restriction(s): _____.

I hereby acknowledge and understand that I am also granting consent for my personal health information to be disclosed to the following person(s): _____. This consent does not apply to disclosures of health care information unrelated to my current condition, nor does it apply to the provision of copies of health records; in both cases, a written authorization must be provided by me or my legal representative.

I acknowledge and understand that I, or my representative, promptly upon request, may inspect, request correction of and obtain information from my patient records. I further acknowledge and understand that I may revoke this consent in writing at any time except to the extent that the provider has already acted in reliance on this consent.

In the event the patient is a minor under the age of eighteen (18), I certify that I, the undersigned guardian, hereby consents to the foregoing on behalf of my minor child: _____.

By signing this Consent for Treatment and Disclosure of Patient Information, I acknowledge that I have read and understood the foregoing notice.

Print Name: _____ **DOB:** _____

Signature: _____ **Date:** _____

2018 ASSIGNMENT OF BENEFIT FORM

Name (Last, First): _____

Policy#:_____ DOB: _____

I hereby authorize, instruct and direct my insurance carrier to issue and mail payment check(s) to Atlantic Medicine & Wellness, LLC, 2399 Route 34, Suite A-5, Wall Township, NJ 08736**. In the event my current policy prohibits direct payment to Atlantic Medicine & Wellness, LLC, I hereby understand and acknowledge that I am responsible to make payment(s) directly to Atlantic Medicine & Wellness, LLC for any and all professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This assignment serves as my written authorization for assigning all my rights and benefits payable under my insurance coverage to Atlantic Medicine & Wellness, LLC. I further understand and acknowledge that I am responsible for any amount not covered by insurance for medical (including nutrition), chiropractic, physical therapy, mental health counseling, massage and/or acupuncture services rendered to me by Atlantic Medicine &Wellness, LLC in connection with any insurance policy and/or claim otherwise payable to me. This payment will not exceed my indebtedness to Atlantic Medicine & Wellness, LLC, and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment that is not prohibited by law.

This assignment is irrevocable. In the event I would like to revoke this assignment, I will request such revocation in writing to Atlantic Medicine & Wellness, LLC. In the event I should not receive a written confirmation from Atlantic Medicine & Wellness, LLC within ten (10) days of my request, it will be deemed that such request has been authorized.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I authorize the doctor to initiate a complaint to my health insurance and/or the Insurance Commissioner or any other government agency for any reason on my behalf.

By signing this Assignment of Benefits Form, I acknowledge that I have read and understood the foregoing notice.

_____ _____

Signature of Policyholder **Date**

Atlantic Medicine & Wellness is now complying with Federal guidelines and utilizing Electronic Health Records. As part of the requirements of this conversion, we are also **mandated by Federal law** to capture more detailed information about you in the several questions noted below. Won't you kindly answer the questions below and sign where indicated. Your patience and cooperation are very much appreciated.

FIRST NAME: _____ **LAST NAME: _____**

DOB: _____ **GENDER:** ☐ **Male** ☐ **Female**

LANGUAGE: ☐ English ☐ Other: _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE:
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

ALLERGIES: ☐ No Known ☐ Other: _____

MEDICATIONS: ☐ None ☐ List name and dosage: _____

_____

(please use reverse side for more room)

TOBACCO USE:
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

_____ _____

Patient Signature **Date**

Office Signature: _____ **Date:_____**