

Physician's Choice, Inc.
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CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: ____/____/____
Last First

Age: _____ Date of Birth: ____/____/____ Social Security No: ____-____-____

Address: _____
Street

City State Zip Code

Home Phone: ____-____-____ Cell Phone: ____-____-____

Daytime Phone: ____-____-____ Work Phone: ____-____-____

Email: _____

Employer: _____

Occupation: _____

Spouse: _____

Emergency Contact: _____
Name Telephone

Text Message reminders for office visits? ___N ___Y Cell _____

_____ Please do not send mail or contact me at home.

_____ Please do not send mail or contact me at home – send mail to:

Payment is due at the time of service
We Accept Cash, Check, Visa, MasterCard, Discover, American Express & Care Credit

Everyday holds the possibility of a miracle.

Name (last) _____ (first) _____ Date ____/____/____

Date of Birth ____/____/____ Age ____ Single ____ Married ____ Widowed ____ Divorced ____

How did you hear about Physicians Choice ? _____

Illness or Medical Problems: _____

Previous Cosmetic / Plastic Surgery? _____

Allergies to Medications or Foods: _____

Medications that you are currently taking (use back if necessary)

Medication and Dosage	Purpose	Prescribing Doctor
_____	_____	_____
_____	_____	_____

Nutritional Supplements - _____

Primary Care Physician - _____ GYN - _____

Please place S if you or F if your immediate family has or have had any of the following diseases or medical problems:

_____ Heart Disease / Stroke	_____ Diabetes
_____ Heart Murmur	_____ Kidney or Bladder
_____ High Blood Pressure	_____ Thyroid
_____ Elevated Cholesterol	_____ Chronic or Migraine Headaches
_____ Chest Pain	_____ Neurological / Seizure
_____ Anemia or Blood Related Diseases	_____ Asthma or Lung
_____ Cancer	_____ Sinus or Allergies
_____ Frequent Constipation or Diarrhea	_____ Shortness of Breath
_____ Heartburn or Indigestion	_____ Eye
_____ Other Stomach or Colon Illness	_____ Hearing
_____ Gall Bladder or Liver Disease	_____ Skin
_____ Arthritis or Joint	_____ Chronic Fatigue or Fibromyalgia
_____ GYN (Surgery, HRT or BCP)	_____ Frequent or Long Term Use of Steroids
_____ Depression / Psychological	_____ Addiction
_____ Marijuana	_____ Alcohol – Amount _____
_____ Smoking / Tobacco - Amount ? _____	Would You Like to STOP Smoking _____

Other: _____