

Bret J. Rodgers, MD, FACS

DATE: _____

PATIENT INFORMATION

Name: _____

(Last name)

(First name)

(Middle initial)

Address: _____

(Street)

(City)

(State)

(Zip)

E-mail address: _____

Home Telephone Number : (____) _____ - _____ Cell Number : (____) _____ - _____

Social Security Number: _____ - _____ - _____ Birthdate: ____ / ____ / ____ Age: _____ Sex: _____

Employer: _____ Work Phone Number: (____) _____ - _____

Emergency Contact Name _____ Phone # _____ Relationship _____

RESPONSIBLE PARTY INFORMATION

Name: _____

(Last name)

(First name)

(Middle initial)

Address: _____

(Street)

(City)

(State)

(Zip)

Home Telephone Number : (____) _____ - _____ Birthdate: ____ / ____ / ____ Age: _____ Sex: _____

Social Security Number: _____ - _____ - _____

Employer: _____ Work Phone Number : (____) _____ - _____

Spouse's Name: _____ Birthdate: ____ / ____ / ____ Age: _____

Employer: _____ Work Phone Number: (____) _____ - _____

HEALTH INSURANCE ***Have your insurance cards available for copying by receptionist.

Primary Insurance: _____ ID # _____

(Name of Ins)

(Address)

Cardholder: _____ Group # _____ Effective Date _____ Co-pay \$ _____

Secondary or Supplemental Insurance: _____ ID # _____

(Name of Ins)

(Address)

Cardholder: _____ Group # _____ Effective Date _____ Co-pay \$ _____

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Medical History

Patient Name: _____ Doctors Name: _____

When was your last physical exam? _____ By whom? _____

Do you have any neurological conditions? Yes No _____

Do you have any chronic heart conditions including high blood pressure or mitral valve prolapse? Yes No _____

Do you have any lung conditions? Yes No _____

Do you have any urinary or kidney disease? Yes No _____

Do you have diabetes or insulin resistance? Yes No _____

Do you have any liver conditions? Yes No _____

Do you have any problems with your eyes/vision? Yes No _____

Do you have stomach or reflux problems? Yes No _____

Do you have thyroid problems? Yes No _____

Do you have anemia, HIV, or any blood disorders? Yes No _____

Do you have problems with bruising easily or bleeding? Yes No _____

Do you have any chronic skin conditions including latex allergy/sensitivity? Yes No _____

Do you have a history of frequent cold sores or fever blisters? Yes No _____

Do you have any gynecological problems? Yes No _____

Are you presently pregnant? Yes No _____

Do you have problems with healing? Yes No _____

Do you have any psychiatric conditions? Yes No _____

Do you smoke cigarettes, cigar, or a pipe? Yes No If yes, how many per day _____

Do you drink alcohol? Yes No If yes, frequency and quantity _____

Please list any other medical conditions you suffer from: _____

Please list all medications you take including vitamins or herbal: _____

Please list any surgeries you have had, date of surgery, and complications from surgery: _____

List any medications you are allergic to and explain the reaction after taking the medication: _____

Patient/Guardian Signature: _____ Date: _____

Physician Signature: _____ Date: _____