PATIENT INFORMATION

DATE_____ REFERRED BY_ _____

NAME_____ AGE_____

ADDRESS_____APT_____

CITY_____STATE_____ZIP_____**DATE OF BIRTH**_____

EMAIL ADDRESS:_____ May we contact you this way? Y / N

TEL: (Home)_____ (Cell)_____ (Bus)_____

OCCUPATION_____ SOCIAL SECURITY #_____

REASON FOR VISIT_____

PHARMACY NAME:_____ **PHARMACY TEL:**(_____)_____-_____

PHARMACY ADDRESS: _____

INSURANCE COMPANY_____POLICY#_____

INSURED'S NAME _____ INSURED'S DOB_____

MAJOR ILLNESSES _____

DAILY MEDICATIONS: _____

PREVIOUS SURGERY & DATE _ _____

_____

Family Physician _____ Medication Allergies _____ Latex Allergy? Y / N

HAVE YOU HAD: (Check if 'yes') Hepatitis___ Blood Transfusions___ Excessive Bleeding___ Easy Bruising___
Personal or Family History of: Breast Cancer____ Heart Condition____ Diabetes____ High Blood Pressure____
Malignant Hyperthermia___ Fever after Exercise___ Anesthesia Issues___ Dark Urine___ Muscle Spasms___

Details _____

DO YOU TAKE: Aspirin, Motrin, Advil, Etc. on a Regular Basis? _____ Coumadin or Plavix?_____

ARE YOU: Allergic To Xylo/Novocaine? ____ Epinephrine Sensitive____ Last Mammogram_____

WHO SHOULD BE NOTIFIED IN CASE OF EMERGENCY?_____ ( ) _____

I understand that I am responsible for payment in full of all charges. I authorize payment of benefits from my insurance to be paid directly to Gary S. Berger, M.D. I also authorize Dr. Berger to release to my insurance company any and all information necessary for the processing of insurance claims and any necessary appeals.

Signature:_____ Date:_____

I have received and/or reviewed a copy of Dr. Berger's 'Notice of Privacy Practices for Protected Health Information' as required by the Health Insurance Portability & Accountability Act of 1996

Signature:_____ Date:_____