

Patient Demographic & Information

****PLEASE PRINT LEGIBLY AND COMPLETE ALL INFORMATION****

Name: _____ I prefer to be called: _____
Date of Birth: _____ Social Security Number: _____ - _____ - _____ Gender: Male / Female
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____
Marital Status: ___ Single ___ Married ___ Widowed ___ Separated ___ Divorced
* Email address: _____
If Student, Name of School: _____ College students only: ___ Full-time ___ Part-time
Employer: _____ Occupation: _____
Person to contact in case of emergency: _____ Relationship: _____ Phone# _____
*Please list your emergency contact on your H.I.P.A.A form
Whom may we thank for referring you to our office? (If MD list name and telephone number):

Guarantor's Information (person that is attending the appointment with the patient @ this time)

Relationship to patient: ___ Self ___ Spouse ___ Parent ___ Other
Guarantor's name: _____ Social Security Number: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Cell: _____ Work: _____

Insurance / Responsible Party Information

Primary Insurance Company: _____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
ID# on card: _____ Group/Policy # _____
Policyholder's Name: _____ Policyholder's Relationship to patient: _____
Policyholder's Date of Birth: _____ Policyholder's Social Security # _____
Name of Employer: _____ Address: _____

Secondary Insurance Company: _____ Phone: _____
Claims Address: _____ City: _____ State: _____ Zip: _____
ID# on card: _____ Policy # _____
Policyholder's Name: _____ Policyholder's Relationship to patient: _____
Policyholder's Date of Birth: _____ Policyholder's Social Security # _____
Name of Employer: _____ Address: _____

I hereby authorize DOUGLAS R. TURGEON, M.D., P.A. to furnish information to insurance carrier concerning me and / or my dependants illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand and agree that regardless of my insurance status, I am responsible for the balance on my account and / or my dependents for any professional services rendered. I understand that I am responsible for any amount not covered by insurance. I certify that the information on this form is true and correct to the best of my knowledge and I will notify DOUGLAS R. TURGEON, M.D., P.A. of any changes. (A copy of this authorization shall be as valid as the original.)

SIGNATURE OF PATIENT: _____ DATE: _____

If patient is a minor (under the age of 18), parent or legal guardian must sign.

DOUGLAS R. TURGEON, M.D., P.A.
MEDICAL INFORMATION

Date: _____

PATIENT NAME: _____ DOB: _____ Height: _____ Weight _____

WHAT IS YOUR CHIEF COMPLAINT? _____ Right Left Bilateral

DATE OF INJURY: _____

PLEASE BRIEFLY DESCRIBE HOW YOU INJURED YOURSELF: _____

WHEN DID YOU INJURE YOURSELF (DATE): _____

WHERE DID YOU INJURE YOURSELF (HOME, PARK, ETC.....): _____

FAMILY HISTORY OF ANY ILLNESS (PLEASE GIVE DETAIL ON WHICH FAMILY MEMBER):

PRIMARY CARE PHYSICIAN'S FULL NAME: _____ PHONE: _____ FAX: _____

TOBACCO USE: YES___ NO___ (IF YES PLEASE ANSWERS NEXT QUESTIONS): PACKS PER DAY? _____
YEARS? _____

ALCOHOL USE: YES___ NO___ (IF YES PLEASE ANSWERS NEXT QUESTIONS): DRINKS PER DAY? _____
YEARS? _____

PLEASE LIST ALL KNOWN DRUG ALLERGIES: _____

***ARE YOU ALLERGIC TO LATEX? YES___ NO___ (IF YES WHAT IS THE REACTION): _____

PLEASE LIST ALL CURRENT MEDICATIONS: _____

RECENT ILLNESSES OR SYMPTOMS: _____

PREVIOUS (or) PAST SURGICAL HISTORY (PLEASE LIST AND GIVE DATES)

HAVE YOU EVER HAD PROBLEMS WITH ANESTHESIA? IF SO, WHAT?

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS OR ILLNESSES? (Please answer YES or NO to each or circle NONE):

Abnormal Blood Pressure _____ Heart Disease _____ Infectious Disease _____ Hepatitis _____ Anemia _____

Stomach Ulcers _____ Cancer _____ Blood Disorders _____ Stroke _____ Diabetes _____ Reflux _____

Blood Transfusions _____ High Cholesterol _____ Asthma _____ Thyroid _____ SLEEP APNEA _____ NONE

Please give any additional details if you answered “yes” to any of the above:

Other Medical Conditions/Innnesses not listed above:
