THIS INFORMATION IS VERY IMPORTANT FOR OUR RECORDS AND YOUR MEDICAL CARE. PLEASE READ CAREFULLY AND FILL OUT COMPLETELY. PLEASE PRINT. THANK YOU!!!

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

SEX _____ RACE _____ BIRTHDATE _____

PHONE _____ MARITAL STATUS _____

SOCIAL SECURITY NUMBER _____

EMPLOYER _____

OCCUPATION _____ WORK # _____

SPOUSE'S NAME _____

SPOUSE EMPLOYED BY _____

OCCUPATION _____ WORK # _____

NAME OF PARENT (IF A MINOR) _____

PAYMENT PROCEDURE: We will be glad to file your insurance. Please provide us with current information. All co-payments are expected at the time of service. If you have any questions, please see the receptionist.

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

If you are not the policyholder, please provide the following:

Policyholder Name: _____

Policyholder DOB: _____

Policyholder SSN: _____

I hereby authorize Lakeside Primary Care/David C. Harrison, MD to release medical information to the insurance company(ies) listed above. Also, by my signature and copies thereof, I authorize payment directly to Lakeside Primary Care/David C. Harrison, MD for benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization and any attorney or collection fees, if applicable.

_____

Patient Signature *Date*

In case of emergency, who should be contacted?

Name _____

Relationship _____ Phone _____

REFERRED BY: _____

Who is your:

Cardiologist: _____

Gynecologist: _____

Dentist: _____

Other Doctor: _____

DO YOU HAVE AN ALLERGY OR SENSITIVITY TO ANY MEDICINES? ☐ NO ☐ YES IF YES, LIST NAME OF DRUG AND TYPE OF REACTION

_____

_____

DO YOU TAKE ANY MEDICINE ON A REGULAR BASIS?_____ IF YES, LIST NAME OF DRUG, STRENGTH, HOW OFTEN TAKEN AND FOR WHAT REASON.

_____

_____

_____

PLEASE LIST DATES AND REASONS FOR ANY MAJOR HOSPITALIZATIONS OR SURGICAL PROCEDURES

_____

_____

_____

PLEASE LIST SIGNIFICANT MEDICAL CONDITIONS

_____

_____

FAMILY HISTORY: Include name, age, and health status

(If deceased, list age of and cause of death)

Mother: _____

Father: _____

Siblings: _____

Children _____

Check Illnesses which have occurred in any of your blood relatives. ☐ diabetes ☐ cancer ☐ high blood pressure

☐ heart disease ☐ stroke ☐ blood disorders ☐ asthma

☐ neurological disease ☐ anxiety/depression ☐ allergies

☐ kidney disease ☐ liver disease ☐ alcoholism

☐ other: _____

Do you use tobacco now? ☐ no ☐ yes

In the past ☐ no ☐ yes How long? _____

Type and daily amount _____

Do you drink alcohol? ☐ no ☐ yes

Type and weekly amount _____

How long? _____

Signature _____

Date _____