code: GF006

Patient Demographics

Date

Patient Information:

First Name

Middle Initial

Last Name

Sex

Date of Birth

Home Phone

Cell Phone

Preferred Phone

Patient Address Line 1

Patient Address Line 2

City

State

Zip

Email

Language

Communication Preference

Ethnicity

Religion

Race

Marital Status

Spouse's Name

Spouse's Contact Phone

Patient Employment Status

Professional Title

Employer Name

Work Phone

Fax Number

Employer Address Line 1

Employer Address Line 2

Employer City

Employer State

Employer Zip

Primary Insurance Information:

Primary Insured's Name

Date of Birth

Primary Relationship to Insured

Primary Insured's SSN

Insured's Home Phone	Cell Phone	Work Phone	Driver's License #
Primary Insurance Name	Primary Plan Name	Primary Subscriber ID	Primary Group No.

Secondary Insurance Information:

Secondary Insured's Name	Date of Birth	Secondary Relationship to Insured	Secondary Insured's SSN
Insured's Home Phone	Cell Phone	Work Phone	Driver's License #
Secondary Insurance Name	Secondary Plan Name	Secondary Subscriber ID	Secondary Group No.

Emergency Contact:

Emergency Contact Name	Emergency Contact Relationship to Patient	
Emergency Contact Home Phone	Emergency Contact Cell Phone	Emergency Contact Work Phone
Emergency Contact Address Line 1	Emergency Contact Address Line 2	
Emergency Contact City	Emergency Contact State	Emergency Contact Zip
Primary Physician Name	Primary Physician Phone	
Whom may we thank for referring you?		

Health History

Current medical conditions:

Month/Year Diagnosed	Medical Problem	Treatment/Medication
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Surgeries:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Hospitalizations:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Medications:

Name of Drug	Strength	Frequency Taken
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Allergies

Name	Reaction
1)	_
2)	_
3)	_
4)	_

Exercise:

Type	Intensity	Frequency
Type	**Intensity**	**Frequency**

Social History

Caffeine:

Caffeine Beverage?

◯ Yes
◯ No

Type (coffee, tea, soda, etc.)

Amount

Frequency

Alcohol:

Alcoholic Beverage?

◯ Yes
◯ No

Frequency

Amount

Smoking Status

Patient Smoking Status

Patient Smoking Frequency

Patient Smoking Start Date

Patient Smoking End Date

Do you currently use recreational or street drugs?

◯ Yes
◯ No

Have you ever given yourself street drugs with a needle?

◯ Yes
◯ No

Family History

List medical illness and/or cause of death:

Mother

Father

Brother/Sister

Husband/Wife

Son/Daughter

Additional Comments

Signature of Responsible Party

Date