PATIENT'S INFORMATION

(revised 11/11)

Patient's name ____

Address______________________________ **City**______________ **State** ______ **Zip** ______
(PHOTO ID REQUIRED IF POST OFFICE BOX)

Date of Birth ____________ **Age** ____ **Male** _____ **Female**_______

SOCIAL SECURITY # ____________________ **Occupation** ______________________

EMAIL ______________________________

Home Phone#____ - ______- _______ **Work #** ____ - ______ - ________

Cell Phone # ______ - ______ - ________

Family Doctor ____________________________

Address ________________________________ **Phone #** ____ - _____ - _______

How did you hear about our office? (or referred by) __________________________________

RELATIONSHIP TO POLICY HOLDER ____ **SELF** ____ **SPOUSE** _____**PARTNER** ____**CHILD**

NAME OF POLICY HOLDER ______________________________ **DATE OF BIRTH** ________

Our office participates in many insurance plans. You are responsible for any referrals, deductibles and co-pays.
****ANY BALANCES OVER 60 DAYS OLD WILL BE SUBJECT TO A $10.00 REBILLING CHARGE.(EFF 1/1/08)***

Your signature on this form authorizes us to use this signature on file for all commercial & Medicare insurance. It authorizes Dr. Obiedzinski to release and request any and all medical information needed to provide services to me.

I have been given an opportunity to receive a copy of the privacy notice for Dr. Obiedzinski's office. (COPY WILL BE GIVEN UPON REQUEST)
Medicare patients: Your signature here means you have not received the same treatment in the last 61 days. If you did Medicare will not pay and you will receive a bill.

MEDICAID PATIENTS: WE DO NOT TAKE MEDICAID AND YOU WILL BE RESPONSIBLE FOR COPAYS AND DEDUCTIBLES.

Date ___________ **Signature PATIENT/ PARENT/ GUARDIAN:** ____________________________
(PLEASE SIGN)

CIRCLE ALL THAT APPLY *PATIENT NAME* ______________________________

NEUROPATHY
DIAB TYPE 1 CONTROLLED YES NO
DIAB TYPE 2 CONTROLLED YES NO
EASY BRUISING
VD
ANEMIA
BLINDNESS
BLINDNESS PARTIAL
MACULAR DEGENERATION
CATARACTS
BLOODY NOSE
HEART PALPITATIONS
PERSISTENT COUGH
VOMITING
KIDNEY STONES
KIDNEY DISEASE
CALF PAIN
NIGHT CRAMP
TRANSFUSION REACTIONS
HIGH BLOOD PRESSURE
HEPATITIS
THYROID HYPER
THYROID HYPO
ARTHRITIS RHEUMATOID
FEVERS
EXCESSIVE TEARING
SINUS PROBLEMS
ANKLE SWELLING
FOOT SWELLING
HEART MURMUR
ASTHMA
EMPHYSEMA

HEARTBURN
GERD
RECTAL BLEEDING
URINE BLOODY
POOR CIRCULATION
CHRONIC SKIN RASH
TREMORS/PARKINSON'S
RHEUMATIC FEVER
CARDIAC A FIB
CARDIAC MI
CARDIAC PACEMAKER
HEART FAILURE
DEFIBRILLATOR
ANEURSYM
GOUT
PHLEBITIS
THROMBOSIS
EMBOLISM
GLAUCOMA
WEAKNESS
BLURRED VISION
DOUBLE VISION
DRY EYE
DIZZINESS
SHORTNESS OF BREATH
CHEST PAIN
NAUSEA
BLADDER OVER ACTIVE
BLADDER STONES
JOINT PAIN OR STIFFNESS
OSTEO ARTHRITIS
FIBROMYALGIA

SEIZURES/EPILEPSY
HEMOPHILIA
STOMACH ULCER
CHOLESTEROL
CANCER
OSTEOPOROSIS
OSTEOPENIA
PSYCHIATRIC DISABILITY
SPINAL STENOSIS
SCIATICA
HERNIATED DISC
BULGING DISC
HERNIA
ALZHEIMERS
HEADACHES
MIGRAINES
HIV / AIDS
STROKE / MINI STROKE
SMOKING : EVERYDAY
SOMETIMES
FORMER
NEVER

HEIGHT __________

WEIGHT __________

BLOOD PRESSURE ______

LIST ANY CONDITIONS NOT MENTIONED ABOVE ______________________________________

____

LIST ALL SURGERIES: ____

____

____

SOCIAL HISTORY

CHANGE IN APPETITE	YES	NO
WEIGHT CHANGES	YES	NO
CONTACTS	GLASSES	
DENTURES	YES	NO
DIFFICULTY SWALLOWING	YES	NO
HEARING PROBLEMS	YES	NO
SENSITIVE TO LIGHT	YES	NO
TEA	COFFEE	
ILLICT DRUG USE	YES	NO
MORE THAN SOCIAL DRINKING	YES	NO

NAME ______________________________

***PARENTS* HISTORY** (CIRCLE ALL THAT APPLY)

Your

PARENTS

- HYPERTENSION
- HYPERLIPIDEMIA
- HEART DISEASE
- DIABETES TYPE 1
- DIABETES TYPE 2
- COPD
- THYROID DISEASE
- BREAST CANCER
- COLORECTAL CANCER
- OTHER CANCER
- ALCOHOLISM
- BUNIONS
- FOOT PROBLEMS
- HEEL PAIN
- HAMMER TOES
- GOUT
- MENTAL ILLNESS
- OTHER ______________________________

PLEASE LIST ALL MEDICATIONS;

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PLEASE LIST ALL **MEDICATIONS ALLERGIES AND REACTIONS**:(LATEX,TAPE,IODINE)______________________________

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LIST ANY FOOD ALLERGIES AND REACTIONS ______________________________

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