Premiere Health and Wellness

Patient Information Sheet

Patient Name:_____ DOB: _____ Sex: _____ Ethnicity: _____

Address:_____

City:_____ State:_____ Zip:_____ Phone: _____ Work Phone: _____

E-mail: _____ Social Security Number: _____

Employer: _____

Marital Status: Married___ Single___ Divorced___ Widowed___

ACCOUNT RESPONSIBILITY IF OTHER THAN SELF (Must be completed if patient is a minor)

Person Responsible for Account: _____

DOB: _____ Phone: _____ Relationship:_____ Address:

_____

EMERGENCY INFORMATION
Person to contact in case of emergency: _____

Relationship: _____ Phone:_____

INSURANCE INFORMATION

As a courtesy to our patients, we will file your insurance claim at no charge, however this information must be accurate. If information changes it is the patient's responsibility to update the office accordingly. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release any medical information required to process this claim.

PRIMARY INSURANCE INFORMATION
Primary insurance is through: Self_____ Spouse _____ Mother _____ Father _____

If other than self-please complete the following information:

Name of Insured: _____ Date of Birth: _____

Name of Insurance Company: _____

SECONDARY INSURANCE INFORMATION

Insurance is through: Self_____ Spouse _____ Mother _____ Father _____

If other than self-please complete the following information:
Name of Insured: _____ Date of Birth: _____

Name of Insurance Company: _____

MEDICAL HISTORY (Check all that apply):

Check all the following that you have or have had:

__ Glaucoma
__ Hearing Loss
__ Thyroid Problems
__ Hormonal Problems
__ Pneumonia
__ Emphysema/COPD
__ Asthma
__ Tuberculosis
__ High Blood Pressure
__ Heart Attack
__ Abnormal Pap
__ Ob/Gyn Problems
__ High Cholesterol
__ Stomach Problems
__ Trauma
__ Gallbladder Probs.
__ GI Bleed
__ Colon Polyps
__ Hepatitis
__ Hernias
__ Diabetes
__ Bleeding Problems
__ Inflammatory Bowel
__ Poor Circulation
__ Arthritis
__ AIDS
__ Blood Transfusion
__ Breast Problems
__ Kidney Problems
__ Headaches
__ Seizures
__ Skin Problems
__ Cancer

Additional Notes: _____

Allergies to Medication: NO or YES: _____

Please list all previous surgeries:

__ Hernia
__ Lung
__ Kidney
__ Tubal Ligation
__ Breast
__ Pediatric
__ Heart
__ Appendectomy
__ Surgery for Trauma
__ Vasectomy
__ Cancer
__ Skin Cancer
__ Tonsillectomy
__ Testicular
__ Head and Neck
__ Ear
__ Gallbladder
__ Vascular
__ Colon
__ Hysterectomy
__Ovary
__ Ob/Gyn
__ Eye
__ Back

Additional Remarks: _____
_____

FAMILY HISTORY (Check all that apply):

__ Heart Disease __ Stroke __ Diabetes ___ Migraine ___ Cancer

___ High Cholesterol __ Thyroid __ High Blood Pressure

Additional Remarks: _____
_____

Do you smoke (circle)? Yes No If "Yes", how many packs per day? Number of years? ___

Do you drink alcohol (circle)? Yes No If "Yes", how many packs per day? Number of years? ___

_____ _____
Signature Date