

**Basic Patient Information****Date:** \_\_\_\_\_**Title:**  Mr.  Mrs.  Ms  Miss (check one)**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_**Address Line 1:** \_\_\_\_\_**Address Line 2:** \_\_\_\_\_**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_**Cell Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:**  Male  Female **Email:** \_\_\_\_\_**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Marital Status:**  Single  Married  Other**Employment Status:**  Employed  Full Time Student  Part Time Student  Other (check one)**Spouse Data****Is your spouse a patient in the clinic?**  Yes  No**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_**Home Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Work Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_**Employer Data****Name:** \_\_\_\_\_**Address Line 1:** \_\_\_\_\_**Address Line 2:** \_\_\_\_\_**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_**Emergency Contact****Contact Name:** \_\_\_\_\_**Contact Phone:** (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Treatment Authorization**

I hereby authorize this office and its staff and doctors to examine and treat my condition as the doctors deem appropriate and I give authority for these procedures to be performed. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment of services by this office and all outside laboratory or radiology services performed on my behalf. Should collection of past due amount become necessary, I will become responsible for all charges, fees and attorney fees. I (we) hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

**Patients Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent to Treat a Minor**

I (we) being the parents, guardian or custodian of the minor being \_\_\_\_\_, Age \_\_\_\_\_, do hereby authorize, request, and direct this office, its doctors and staff to perform examinations, diagnostic X-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor child is under care of this office’s doctors and staff until legal age. All charges for services and care given to said minor child will be charged directly to me (us) and I (we) will be personally responsible for payment of them. I(we) authorize doctor to release all information necessary to secure payment of benefits. I (we) authorize the use of this signature on all insurance submissions.

**Parent, Guardian or Custodian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Acknowledgement of Receipt**

As required by the Privacy Regulation, I hereby acknowledge that I have received a current copy of the Notice of Privacy Practices of the Dynamic Health Center.

I am aware that the Dynamic Health Center has included a provision that it reserves the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information that it maintains.

**Patients Name** \_\_\_\_\_

**If signed by a representative of the patient:**

**Representative’s Name** \_\_\_\_\_

**Relationship** \_\_\_\_\_

**Patient’s/Representative’s Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(Office Use Only)**

**Authorized Facility Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Good faith effort to obtain receipt: (describe)**

\_\_\_\_\_

**Is it okay to call you at work?**

- Yes       No

**Who can we thank for referring you to our office?**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Family member | <input type="checkbox"/> Attorney         | <input type="checkbox"/> Internet web site | <input type="checkbox"/> Health class   |
| <input type="checkbox"/> Friend        | <input type="checkbox"/> Yellow Pages     | <input type="checkbox"/> Billboard         | <input type="checkbox"/> Brochure       |
| <input type="checkbox"/> Physician     | <input type="checkbox"/> Newspaper ad     | <input type="checkbox"/> TV Commercial     | <input type="checkbox"/> Direct mail ad |
| <input type="checkbox"/> Employer      | <input type="checkbox"/> Sign on building | <input type="checkbox"/> Radio             | <input type="checkbox"/> Other          |

**If you selected 'Yellow Pages' please indicate which Yellow Pages (Yellow Pages or Yellow Book):**

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**If you selected 'family member', 'friend', or 'physician' please enter their name below:**

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**If you selected 'other' please describe**

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**Medical Conditions:**

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Stroke        |

**Surgeries:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Cardiovascular procedure | <input type="checkbox"/> Cervical disc procedure | <input type="checkbox"/> Hysterectomy                   |
| <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Laminectomies            | <input type="checkbox"/> Radical prostatectomy   | <input type="checkbox"/> Transurethral prostate surgery |

**Allergies:**

- |                               |   |  |                                 |
|-------------------------------|---|--|---------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish and Shellfish | <input type="checkbox"/> Milk or Lactose | <input type="checkbox"/> Peanut |
| <input type="checkbox"/> Soy  | <input type="checkbox"/> Sulfites           | <input type="checkbox"/> Wheat/Gluten    |                                 |

**Social History:**

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Caffeine used occasionally   | <input type="checkbox"/> Caffeine used often            | <input type="checkbox"/> Chew tobacco occasionally | <input type="checkbox"/> Chew tobacco often           |
| <input type="checkbox"/> Drink alcohol occasionally   | <input type="checkbox"/> Drink alcohol often            | <input type="checkbox"/> Exercise not at all       | <input type="checkbox"/> Exercise occasionally        |
| <input type="checkbox"/> Exercise often               | <input type="checkbox"/> Experience stress occasionally | <input type="checkbox"/> Experience stress often   | <input type="checkbox"/> Smoke 1 pack or less per day |
| <input type="checkbox"/> Smoke more than 1 pack a day | <input type="checkbox"/> Wear seat belts always         | <input type="checkbox"/> Wear seat belts never     | <input type="checkbox"/> Wear seatbelts usually       |

**Family History:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Arthritis (parent)      | <input type="checkbox"/> Arthritis (sibling)      | <input type="checkbox"/> Cancer (parent)              | <input type="checkbox"/> Cancer (sibling)              |
| <input type="checkbox"/> Cholesterol (parent)    | <input type="checkbox"/> Cholesterol (sibling)    | <input type="checkbox"/> Diabetes (parent)            | <input type="checkbox"/> Diabetes (sibling)            |
| <input type="checkbox"/> Heart problems (parent) | <input type="checkbox"/> Heart problems (sibling) | <input type="checkbox"/> High blood pressure (parent) | <input type="checkbox"/> High blood pressure (sibling) |
| <input type="checkbox"/> Psychiatric (parent)    | <input type="checkbox"/> Psychiatric (sibling)    | <input type="checkbox"/> Stroke (parent)              | <input type="checkbox"/> Stroke (sibling)              |
| <input type="checkbox"/> Thyroid (parent)        | <input type="checkbox"/> Thyroid (sibling)        |   |  |

**Substance Use:**

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Alcohol (past)      | <input type="checkbox"/> Alcohol (present)      | <input type="checkbox"/> Amphetamines (past) | <input type="checkbox"/> Amphetamines (present) |
| <input type="checkbox"/> Barbiturates (past) | <input type="checkbox"/> Barbiturates (present) | <input type="checkbox"/> Cocaine (past)      | <input type="checkbox"/> Cocaine (present)      |
| <input type="checkbox"/> Crystal Meth (past) | <input type="checkbox"/> Crystal Meth (present) | <input type="checkbox"/> Heroine (past)      | <input type="checkbox"/> Heroine (Present)      |
| <input type="checkbox"/> Marijuana (past)    | <input type="checkbox"/> Marijuana (present)    |  |   |

**Male Children:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

**Female Children:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Under 6 years | <input type="checkbox"/> Under 10 years | <input type="checkbox"/> Under 19 years |
|--|---|---|

**Occupational Activities:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Business owner           | <input type="checkbox"/> Clerical/secretarial | <input type="checkbox"/> Computer user         |
| <input type="checkbox"/> Construction   | <input type="checkbox"/> Daycare/childcare        | <input type="checkbox"/> Executive/legal      | <input type="checkbox"/> Food service industry |
| <input type="checkbox"/> Health care    | <input type="checkbox"/> Heavy equipment operator | <input type="checkbox"/> Heavy manual labor   | <input type="checkbox"/> Home services         |
| <input type="checkbox"/> Household      | <input type="checkbox"/> Light manual labor       | <input type="checkbox"/> Manufacturing        | <input type="checkbox"/> Medium manual labor   |

# Review of Systems:

Have you had trouble with any of the following:

## Cardiovascular:

	'No' for ALL _____		
	Present	Past	No
Poor Circulation			
High Blood Pressure			
Aortic Aneurism			
Heart Disease			
Heart Attack			
Chest Pain			
High Cholesterol			
Pace Maker			
Jaw Pain			
Irregular Heartbeat			
Swelling of Legs			

## Genitourinary:

	'No' for ALL _____		
	Present	Past	No
Kidney Disease			
Lower Side Pain			
Burning Urination			
Frequent Urination			
Blood in urine			
Kidney Stone			

## Hematologic/Lymphatic:

	'No' for ALL _____		
	Present	Past	No
Hepatitis			
Blood Clots			
Cancer			
Easy Bruising			
Easy Bleeding			
Fevers/Chills/Sweats			

## Neurologic:

	'No' for ALL _____		
	Present	Past	No
Stroke			
Seizures			
Head Injury			
Brain Aneurysm			
Numbness			
Severe Headaches			
Pinched Nerves			
Parkinson's Disease			
Carpal Tunnel			
Spinning/Balance			

## Respiratory:

	'No' for ALL _____		
	Present	Past	No
Asthma			
Tuberculosis			
Shortness of Breath			
Emphysema			
Cold/Flu			
Cough/Wheezing			

## Ears/Nose/Throat:

	'No' for ALL _____		
	Present	Past	No
Dizziness			
Hearing Loss			
Sinus Infection			
Nosebleed			
Sore Throat			
Difficulty Swallowing			
Bleeding Gums			

## Eyes:

	'No' for ALL _____		
	Present	Past	No
Glaucoma			
Double Vision			
Blurred Vision			

## Integumentary:

	'No' for ALL _____		
	Present	Past	No
Skin Ulcers			
Skin Disease			
Eczema			
Psoriasis			
Rashes			

## Psychiatric:

	'No' for ALL _____		
	Present	Past	No
Depression			
Anxiety Disorder			
Unusual Stress			

## Constitutional:

	'No' for ALL _____		
	Present	Past	No
Weight Loss/Gain			
Energy Level Problem			
Difficulty Sleeping			

## Allergic/Immunologic:

	'No' for ALL _____		
	Present	Past	No
Hives			
Immune Disorder			
HIV/AIDS			
Allergy Shots			
Cortisone Use			

## Gastrointestinal:

	'No' for ALL _____		
	Present	Past	No
Gallbladder Problems			
Bowel Problems			
Constipation			
Liver Problems			
Ulcers			
Diarrhea			
Nausea/Vomiting			
Bloody Stools			
Poor Appetite			

## Musculoskeletal:

	'No' for ALL _____		
	Present	Past	No
Gout			
Arthritis			
Joint Stiffness			
Muscle Weakness			
Osteoporosis			
Broken Bones			
Joints Replaced			

## Endocrine:

	'No' for ALL _____		
	Present	Past	No
Thyroid Disease			
Diabetes			
Hair Loss			
Menopausal			
Menstrual Problems			