Dear Patient,

In an effort to update the information we have regarding your account, please fill up this form:
PLEASE WRITE CLEARLY

Last Name:_________________ First Name:_____________________ Middle Initial:______

Address:____ Apt. _____________

City:______________ State:______ Zip:________

Home Phone:________________ Cell Phone:_________________ Work Phone:_____________

Date of Birth:_____________ Gender: Male/Female Social Security #:_________________

Race (Circle one): White, Black/African American, American Indian/Alaska Native, Asian,

Native Hawaiian, Pacific Islander, Other, Decline to answer

Name of Insurance Company:_______________________ Member ID #__________________

Pharmacy Name:__________________________ Pharmacy Phone #_____________________

May this office:

1. -Call you at home regarding appointments & medical information? Y or N
2. -Call you on your cell phone regarding appointments & medical information? Y or N
3. -Call you on work voice mail regarding appointments & medical information? Y or N
4. -Speak with another person other than yourself regarding appointments & medical info? Y or N
   **Specify contact name, relation, and phone #__________________________________
5. -May we send you appointment and medical information via postal mail? Y or N
6. -May we send you appointment and medical information via email? Y or N

Do you give this Office permission to access your drug information? Y or N

<u>NOTE:</u>

Please return this form to the window, along with your insurance card and driver's license.

You will be instructed to provide 2 electronic signatures regarding your HIPAA consents and preferences.

Thank you.

MEDICAL HISTORY AND SOCIAL HISTORY

Medical History Section (please circle applicable conditions):

AIDS	Alcholism	Allergies, Seasonal	Alzheimer's Disease
Anemia	Angina	Anorexia Nervosa	Anxiety
Arthritis	Asthma	ADHD	Bipolar
Bronchitis	Cancer	Cardiac Arrhythmia	Cirrhosis
Cholesterol	Colitis	Congestive Heart Failure	Dementia
Depression	Diabetes	Drug Addiction	Fibroids
Fibromyalgia	Gout	HIV Infection	Heart Attack
Headache	Hemorrhoids	High Blood Pressure	Hepatitis
Hodgkin's Disease	Incontinence	Infertility	Leukemia
Liver Disease	Lung Disease	Lupus	Melanoma
Menstrual Dysfun.	Migraine	Obesity	Osteoporosis
Parkinson's Disease	Pneumonia	Prostate Disease	Prostate, Enlarged
Pulmonary Embolism	Rheumatic Fever	Sexual Dysfunction	Scarlet Fever
Stomach Disorder	Stroke	Thyroid Disease	Tumors
Ulcer	Other________________________________		

Family History (please place an "X" in the box that relates the appropriate condition with the respective family member):

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Press.						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						