Primary Insurance Information

Policy Holder’s Name: ____

Relationship to Patient: ______________________ SS#: _____________________ Zip: ____________

Name of Employer: ____

Insurance Co: ____ Group#: _______________________

Member/Subscriber ID#: ____

Secondary Insurance Information

Policy Holder’s Name: ____

Relationship to Patient: ______________________ SS#: _____________________ Zip: ____________

Name of Employer: ____

Insurance Co: ____ Group#: _______________________

Member/Subscriber ID#: ____

Answers to the following questions are for our records only and will be considered confidential.

1. Have you been hospitalized in the past two years? ☐Yes ☐No
2. Have you taken any medications or drugs in the past two years? ☐Yes ☐No
3. Have you ever had any excessive bleeding requiring special treatment? ☐Yes ☐No

Medications

Please list medications you are currently using (i.e., Aspirin, Coumadin, Plavix, Nicotine Patch, NSAID’s, ect.):

____

Allergies

Aspirin: ☐Yes ☐No Penicillin: ☐Yes ☐No Codeine: ☐Yes ☐No

Iodine: ☐Yes ☐No Metals: ☐Yes ☐No Erythromycin: ☐Yes ☐No

Latex: ☐Yes ☐No Other: ____