# New Patient Form

## Patient Information

| Today's Date: | PCP: |
|---|---|
| Patient’s last name: | First: |
| Middle: | |
| Title: | |
| Marital Status: | |
| Home Phone #: | Work Phone #: |
| Cell Phone #: | E-mail Address: |
| Birth Date: | Age: |
| Sex: | |
| Street address: | |
| Social Security no.: | P.O. box: |
| City: | State: |
| ZIP Code: | Occupation: |
| Employer: | Employer phone no.: |
| Chose clinic because/Referred to clinic by (please check one box): | |
| If referred by your doctor, who is the doctor that referred you? | |
| Insurance Information | |
| Person responsible for bill: | Birth Date: |
| Address (if different): | |
| Home Phone #: | |
| Is this person a patient here? | |
| Occupation: | Employer: |
| Employer address: | |
| Employer phone no.: | |
| Is this patient covered by insurance? | |
| Please indicate primary insurance: | Subscriber’s name: |
| Subscriber’s S.S. no.: | Birth Date: |
| Group no.: | Insurance Identification Number: |
| Co-payment: | |
| Patient’s relationship to subscriber: | |
| Name of secondary insurance (if applicable): | Subscriber’s name: |
| Group no.: | Insurance Identification Number: |
| Patient’s relationship to subscriber: | |
| In Case of Emergency | |
| Name of local friend or relative (not living at same address): | Relationship to patient: |
| Home Phone #: | Work Phone #: |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Edmund Fisher, MD, INC or insurance company to release any information required to process my claims. | |
| Patient/Guardian signature: | |
| Date: | |

## Current Medications

| What is the reason for the visit? |
|---|
| Have you had any exams ( MRI, CTS, labs, etc.) related to the reason why you are coming in? |
| If yes, please explain: |

| Current Medications (Write "N/A" if no medications are taken)<br>Name: Please be as Specific as Possible | Strength | Directions | Reason For Taking Medication |
|---|---|---|---|
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| **Are you allergic to any medications?** |
| **If so, please specify name and type of reaction:** |
| **Allergic to Latex?** |
| **Female Patients: Are you pregnant?** |
| **If so, 1st trimester, 2nd trimester, or 3rd trimester** |
| **Please list ANY surgeries you have had in the past:** |
| **Past Medical History: (Include all hospitalizations, chronic health problems, major illnesses)** |
| **Family History: Include cancer, diabetes, heart attacks, high blood pressure, strokes, tuberculosis, and other major illnesses, INCLUDE WHICH FAMILY ASSIOCATIES WITH HISTORY** |

## Review of Systems

Check all responses that apply.

**ENT and mouth**

- ❑ dry mouth
- ❑ dysphonia (difficulty speaking)
- ❑ excessive salivation
- ❑ hearing loss
- ❑ loss of smell
- ❑ nasal obstruction
- ❑ oral bleeding
- ❑ otalgia (ear ache)
- ❑ rhinorrhea (runny nose)
- ❑ throat pain
- ❑ tongue swelling
- ❑ vertigo
- ❑ dysphagia (difficulty swallowing)
- ❑ itching ears
- ❑ foul smell
- ❑ hoarseness
- ❑ mouth mass
- ❑ odynophagia (painful swallowing)
- ❑ oral pain
- ❑ otorrhea (ear drainage)
- ❑ sound sensitivity
- ❑ tinnitus
- ❑ ulcers

**Musculoskeletal**

- ❑ neck mass
- ❑ neck pain
- ❑ neck stiffness
- ❑ loss of mobility
- ❑ swelling
- ❑ muscle pain
- ❑ arthritis
- ❑ bone problem

**Constitutional/Symptom**

- ❑ fatigue
- ❑ fever
- ❑ night sweats
- ❑ weight gain
- ❑ weight loss

**Genitourinary**

- ❑ increased urinary frequency
- ❑ leaking

## Review of Systems

**Neurological**
- ❑ confusion
- ❑ decreased sensation
- ❑ headache
- ❑ increased sensation
- ❑ memory loss
- ❑ sensitivity
- ❑ tremor

**Respiratory**
- ❑ cough
- ❑ shortness of breath
- ❑ wheeze

**Integumentary**
- ❑ rash
- ❑ itching skin
- ❑ bleeding skin
- ❑ blisters

**Psychiatric**
- ❑ depression

**Allergic/immunologic**
- ❑ allergic rhinitis
- ❑ increased infections

**Cardiovascular**
- ❑ chest pain
- ❑ dyspnea(difficult breathing)
- ❑ increased heart rate

**Gastrointestinal (G.I)**
- ❑ abdominal pain
- ❑ constipation
- ❑ diarrhea
- ❑ heartburn
- ❑ indigestion
- ❑ vomiting

| Patient Social History | |
|---|---|
| **Smoking Status:** | |
| **Date Started Smoking:** | **Date Quit Smoking:** |
| **# of packs per day:** | **Total Years Smoking:** |
| **Do you, or have your ever used any recreational street drugs?** | |
| **Please List:** | |