PATIENT INFORMATION

LAST NAME ______________________ FIRST NAME ______________________ MID INIT__________

ADDRESS ______________________ DATE OF BIRTH ______________________ AGE ____________

CITY ______________________ SEX M ☐ F ☐

STATE ______________________ ZIP____________ BIRTHPLACE ____________________ MARITAL STATUS ____________

HOME PHONE ____________________ CELL PHONE ____________________ WORK PHONE ____________________

OCCUPATION ______________________ EMPLOYER ______________________

EMAIL ______________________

ADDITIONAL PERSON TO CONTACT (SPOUSE, NEIGHBOR, FRIEND OR RELATIVE) — MUST FILL OUT

NAME ______________________ RELATIONSHIP ____________________

ADDRESS ______________________

HOME PHONE ____________________ CELL PHONE ____________________ WORK PHONE ____________________

INSURANCE / PAYSOURCE — MUST FILL OUT, EVEN IF SELF-PAY AND/OR NOT FILING INSURANCE

PRIMARY ______________________ SECONDARY ______________________

POLICY HOLDER ______________________ POLICY HOLDER ______________________

POLICY HOLDER DATE OF BIRTH ____________________ POLICY HOLDER DATE OF BIRTH ____________________

NUMBER ______________________ NUMBER ______________________

TELEPHONE______________________ TELEPHONE ______________________

MEDICAL INFORMATION — USE BACK OF SHEET IF NECESSARY

ALLERGIES ______________________

CIGARETTES: YES ☐ NO ☐ IF YES, HOW MUCH? ____________________ IF NO, WHEN STOPPED ____________________

FAMILY / PCP / DOCTOR(S) ______________________

LIST ALL MEDICATIONS ______________________

____

LIST ALL PREVIOUS SURGERIES ______________________

LIST ALL MEDICAL CONDITIONS ______________________

I WAS REFERRED BY ______________________

REASON FOR THIS VISIT ______________________

SIGNATURE

By signing

- ✓ I acknowledge that the above information is complete, true and correct.
- ✓ I authorize the release of all medical information as needed to and from Doctor Cuadros.
- ✓ I authorize the use of photography.
- ✓ I acknowledge that I am entering into a physician-patient relationship with Doctor Cuadros.
- ✓ I agree to comply with the care, medication, instructions and treatment prescribed to me by the doctor.
- ✓ I agree to be responsible for all financial charges incurred as a result of my evaluation and treatment.

PATIENT SIGNATURE ______________________ DATE ____________________

Please print this out and bring to your appointment