

# PATIENT INFORMATION

PLEASE COMPLETE PRIOR TO MEETING WITH THE PHYSICIAN

Patient No. \_\_\_\_\_

Date \_\_\_\_\_

Name: Last, First and Middle			Birth Date	Age	Height	Weight
Address			City		State	Zip
Occupation	Medicare No.	Social Security No.	Home Phone ( )		Work Phone ( )	
Insurance Provider		Insurance No.	Cell Phone ( )		Email	
Secondary Insurance Provider		Secondary Insurance No.	Male	Female	Marital Status	

Alternative Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Doctor \_\_\_\_\_

Referring Physician \_\_\_\_\_ Address \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

Primary reason for visit? \_\_\_\_\_

## HAVE YOU HAD:

- |                             |                           |                    |                      |
|-----------------------------|---------------------------|--------------------|----------------------|
| Kidney Disease ___          | Cancer ___                | Asthma ___         | Fainting ___         |
| Tuberculosis ___            | Hay Fever ___             | Arthritis ___      | Hepatitis ___        |
| Heart Attack/Chest Pain ___ | Stroke ___                | Migraine ___       | Seizures ___         |
| Congenital Heart ___        | Phlebitis (Leg clots) ___ | Easy Bruising ___  | Rheumatic Fever ___  |
| High Blood Pressure ___     | Nervous Breakdown ___     | Stomach Ulcers ___ | Heart Murmur ___     |
| Diabetes ___                | HIV/AIDS ___              | Depression ___     | Mental Illness ___   |
| Thyroid Disease ___         | Back Pain ___             | Sinus Problems ___ | Persistent Cough ___ |

Please list any other illnesses:

\_\_\_\_\_

Please list all medications you are presently taking: (Be sure to list all over-the counter medications, vitamins and supplements)

\_\_\_\_\_

Please list all drugs you are allergic to:

\_\_\_\_\_

## PERSONAL HABITS:

- YES NO 1) Do you regularly smoke? \_\_\_ Pipe \_\_\_ Cigarettes Packs per day \_\_\_ For how long? \_\_\_ Date quit \_\_\_\_\_
- YES NO 2) Do you usually drink more than 6 cups of coffee per day?
- YES NO 3) Do you regularly drink alcohol? \_\_\_ 1oz/day \_\_\_ 2oz/day \_\_\_ 4oz/day \_\_\_ 6oz/day
- YES NO 4) Do you have dentures or bridges?
- YES NO 5) Do you have your teeth capped?
- YES NO 6) Are any teeth loose, chipped or bad?
- YES NO 7) Do you wear contact lenses?
- YES NO 8) Do you take aspirin, vitamin K or vitamin E? How many? \_\_\_\_\_

**NOTICE:** This is a confidential record; no information provided will be released without authorization.

Patient No. \_\_\_\_\_

Please list the names and dates of any operations you have had, including plastic surgery procedures:

Have you or your relatives had an unexplained or serious complication during surgery or anesthesia?

Have you ever had a blood transfusion? \_\_\_\_\_ If so, when? \_\_\_\_\_

To be answered by WOMEN only:

YES NO 1) Are you still having regular monthly menstrual periods?  
YES NO 2) Are you now or have you ever taken birth control pills? If so, when?

How many children born alive? \_\_\_\_\_ How many miscarriages? \_\_\_\_\_

How many cesarean operations? \_\_\_\_\_ Any complication of pregnancy? \_\_\_\_\_

Date of last menstrual period? \_\_\_\_\_ Is it possible you may be pregnant? \_\_\_\_\_

**-- OFFICE USE ONLY--**

Financially Responsible Person	Name (If different from patient/insured)	Home Phone ( )
Financially Responsible Person's Address (if different from patient/insured)		
Financially Responsible Person's Employer	Employer's Address	Work Phone ( )
Preferred Method of Payment: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card (MC/Visa) - Acct # _____ Exp. Date _____		
The undersigned agrees to promptly pay all charges when billed for medical services rendered and the person listed below agree and do hereby become legally responsible for any and all charges incurred for the patient referred to above:  _____ Signed		
All accounts are due within 60 days from the initial date of treatment. Any account over 60 days may be subject to a service charge. In the event of non-payment, you will be responsible for all costs of collection, including attorney's fees.		

**PATIENT INSURANCE AUTHORIZATION**

I, \_\_\_\_\_, hereby authorize Stéphane Corriveau, MD, to apply for benefits for covered services. I request payment from my insurance company be made directly to the above-named physician.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above-named carrier. I permit a copy of this authorization to be used in place of the original. Either the above-named carrier or I may revoke this authorization at any time in writing.

\_\_\_\_\_  
Signature of Subscriber, Beneficiary or Responsible Party

\_\_\_\_\_  
Date