Confidential Patient Information

Name_____ Cell Phone Number_____

Address_____

City_____ State_____ Zip Code_____

Age _____ Date of Birth_____ Martial Status __ Single __ Married __ Widowed __ Divorced

Occupation_____ Employer_____

Employer Address_____ Work Phone Number _____

Name of Wife or Husband_____ Occupation_____

Employer_____ Work Phone Number _____

Patient's Nearest Relative _____ Address _____

Cell Phone Number _____ Work Phone Number_____

Reffered By _____ Address _____

Cell Phone Number _____ Work Phone Number_____

Who should we contact in case of emergency? _____Cell Phone Number_____

Date of Last Physical Examination _____

Have you ever sufferred from:		YES	NO		YES	NO
8.	Dizziness	___	___	8. Asthma	___	___
9.	Back Aches	___	___	9. Neuritis	___	___
10.	Heart Trouble	___	___	10. Digestive Disorders	___	___
11.	Diabetes	___	___	11. Nervousness	___	___
12.	Tuberculosis	___	___	12. Sinus Trouble	___	___
13.	Arthritis	___	___	13. Anemia	___	___
14.	Headaches	___	___	14. Cancer	___	___

What is the reason for this appointment? _____

Others doctors seen for this condition: _____

Have you been treated for any health condition by a physician in the last year? YES NO

Please describe: _____

PAYMENT EXPECTED AT THE TIME OF VISIT Will you be paying today by: ___CASH ___ CREDIT CARD

Name of the person responsible for payment: _____

You Insured? YES or NO Company: _____Policy Number: _____

I understand and agree that health and accident insurance policies are an agreement between an insurance company and me. I further understand that DR. DONOVAN MAY will prepare the necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to DR. DONOVAN MAY will be credited to my account upon receipt. However, I understand and agree that any services provided to me are charged directly to me and that I am personally responsible for payment. I also understand that, if I suspend or terminate my care and treatment, any charges for professional services provided to me will be immediately due and payable.

Patient's Signature_____

Guardian's Signature (if patient under 18yo) _____