TODAY'S DATE:__________

PATIENT INFORMATION:

___ Single ___ Married ___ Other

NAME:____ BIRTHDATE: ___/___/___ SEX: M F

First Middle Last

ADDRESS: ____

Number Street

____ EMAIL ADDRESS: __________________________

City State Zip Code

HOME PHONE: (___)______________ CELL PHONE: (___)_______________ WORK PHONE: (___)______________

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___CHILD

EMPLOYER: _______________________________________ OCCUPATION: _______________________________

WORK ADDRESS: ____

Number Street City State Zip Code

SOCIAL SECURITY NUMBER: ____________________________ DRIVER'S LICENSE NUMBER: ______________

RESPONSIBLE PARTY INFORMATION: RELATIONSHIP TO PATIENT: __ SELF __ SPOUSE __ PARENT __ OTHER

NAME:____ BIRTHDATE: ___/___/___ SEX: M F

First Middle Last

ADDRESS: ____

Number Street City State Zip Code

HOME PHONE: (___)______________ CELL PHONE: (___)_______________ WORK PHONE: (___)______________

ARE YOU: ___ EMPLOYED ___ NOT EMPLOYED ___ STUDENT ___CHILD

EMPLOYER: _______________________________________ OCCUPATION: _______________________________

WORK ADDRESS: ____

Number Street City State Zip Code

SOCIAL SECURITY NUMBER: ____________________________ DRIVER'S LICENSE NUMBER: ______________

INSURANCE INFORMATION:

PRIMARY INSURANCE: ________________________________ SUBSCRIBER'S NAME: ____________________

SUBSCRIBER'S NUMBER:_______________________________ GROUP/POLICY NUMBER: _________________

SECONDARY INSURANCE: ______________________________ SUBSCRIBER'S NAME: ______________________

SUBSCRIBER'S NUMBER:_______________________________ GROUP/POLICY NUMBER: _________________

DO YOU HAVE ANOTHER HEALTH BENEFIT PLAN? ___ YES ___ NO

IS YOUR CONDITION RELATED TO: ____ EMPLOYMENT ____ AUTO ACCIDENT ___ OTHER ACCIDENT

WHO REFFERED YOU TO OUR OFFICE? ____

NAME OF YOUR FAMILY DOCTOR: ____

Name Phone number or city where practice is located

IN CASE OF EMERGENCY, NOTIFY: ____

RELATIONSHIP: ____ PHONE NUMBER: _________________

I authorize Dr. Bresnick and staff to give me reasonable and proper medical care by today's standards.
I, the patient or responsible party, authorize release of medical information for the purpose of processing medical claims.
I also authorize my insurance company to pay benefits directly to Stephen D. Bresnick, M.D., Inc.
I authorize Dr. Bresnick to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

SIGNATURE: ____ **DATE:** __________________

STEPHEN D. BRESNICK, M.D.

NAME:_________________________________ AGE:____ SEX:___ WT:_____ HT:__'/___" MARITAL STATUS:____________

HAVE YOU HAD, OR DO YOU STILL HAVE:	YES	NO	HAVE YOU HAD, OR DO YOU STILL HAVE:	YES	NO
COLD OR COUGH WITHIN THE LAST TWO WEEKS			ALLERGIES OR UNFAVORABLE REACTIONS		
BREATHING PROBLEMS (ASTHMA, ETC.)			TO ANY MEDICATIONS OR SUBSTANCES		
CHEST PAINS OR ANGINA			(PLEASE LIST)		
HEART PROBLEMS			____		
PALPITATIONS, IRREGULAR OR FAST HEARTBEAT			____		
SHORTNESS OF BREATH AT ANY TIME			SURGERY (PLEASE LIST TYPE AND DATES)		
HIGH BLOOD PRESSURE			INCLUDE ALL COSMETIC SURGERY		
ANY CIRCULATORY PROBLEMS			____		
BLOOD DISEASE (ANEMIA, ETC.)			____		
BLEEDING PROBLEMS			____		
ANY IMMUNE PROBLEMS OR DISEASE			ANY MEDICATION OR PILLS WITHIN 3 YEARS		
LIVER DISEASE (HEPATITIS, JAUNDICE, ETC.)			(PLEASE LIST)		
STOMACH PROBLEMS (ULCERS, ETC.)			____		
INTESTINAL PROBLEMS			____		
NECK OR BACK PAIN OR INJURIES			____		
SEIZURES			DO YOU TAKE ASPIRIN, ADVIL OR OTHER		
HEADACHES			ANTI-INFLAMMATORY MEDICATIONS		
STROKE OR TEMPORARY PARALYSIS			HAVE YOU EVER SMOKED		
PSYCHIATRIC OR PSYCHOLOGICAL TREATMENT			HOW MUCH PER DAY_____ YEARS _____		
ANY VISUAL OR EYE PROBLEMS (DRYNESS, ETC.)			IF YOU'VE QUIT, WHEN_________________		
GLASSES OR CONTACT LENSES			DO YOU DRINK ALCOHOL		
DIABETES			HOW MUCH PER WEEK_________________		
THYROID PROBLEMS			WHEN WAS YOUR LAST PHYSICAL EXAM		
KIDNEY OR BLADDER PROBLEMS			____		
ANY PROBLEMS DURING PREGNANCY			WHEN WAS YOUR LAST MENSTRUAL		
PROBLEMS WITH ALCOHOL OR DRUG ABUSE			PERIOD ______________________________		
WEIGHT CHANGES IN THE PAST YEAR			HAVE YOU BEEN TOLD YOU HAVE ANY		
CONNECTIVE TISSUE DISEASE (LUPUS,			OTHER DISEASES NOT MENTIONED ABOVE?		
RHEUMATOID ARTHRITIS, SCLERODERMA, ETC.)			IF YES, PLEASE LIST THEM:		
COLD SORES OR OTHER HERPES INFECTIONS			____		
CANCER OF ANY TYPE			____		

REASON FOR THIS VISIT:_____________________________

IS IT OKAY WITH YOU TO SEND A THANK YOU NOTE TO THE PERSON WHO REFERRED YOU TO US? ___YES ___NO

WHO IS YOUR PERSONAL PHYSICIAN? ______________________________ CITY OF HIS/HER PRACTICE:_________________

PERSONAL INFORMATION INITIAL CONSULTATION

* IF YOU NEED ADDITIONAL SPACE, CHECK HERE___& USE THE BACK OF THIS SHEET