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PATIENT INFORMATION

NAME :	**DATE OF BIRTH:**		**ACCOUNT NUMBER:**
ADDRESS:	**CITY, STATE, ZIP:**		**HOME PHONE:**
MOBILE:	**WORK PHONE:**	WORK EXT:	**E-MAIL:**

BEST # TO REACH ME 9-5	Home: ☐	Work: ☐	Mobile: ☐
LEAVE MESSAGE ON MY:	Home: ☐	Work: ☐	Mobile: ☐
Add corrections:			

IN CASE OF EMERGENCY CALL:	Name:	Phone:
	Relationship:	
PATIENT'S EMPLOYER:	Employer:	Occupation:
	Retired: ☐	
PREFERRED PHARMACY:	NAME:	ADDRESS:
	PHARM. PHONE:	
PRIMARY CARE PROVIDER:	Dr. Name:	Dr. Phone:
Add corrections:		

PATIENT RESPONSIBILITIES: All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. It is customary to pay for services when rendered unless other arrangements have been made in advance. **A collection fee will apply to any account with a balance past due 90 days.**

INSURANCE AUTHORIZATION AND ASSIGNEMENT: I hereby authorize Fine and Gillette, MD to furnish information to my insurance carriers concerning my illness and treatment, and I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

***SIGNATURE OF PATIENT OR PERSONAL REP. _____ DATE:**

I authorize Fine & Gillette to share information about my health with the following:

Parent: ☐	Children: ☐	Spouse: ☐	Signif. Other: ☐

***SIGNATURE:_____ DATE:**

PLEASE REVIEW THE FOLLOWING AND CHECK THE BOXES THAT APPLY TO YOU:

NAME: **BIRTHDATE:** **APPT DATE:**

HAVE ANY OF THESE SYMPTOMS OR PROBLEMS DEVELOPED SINCE THE LAST VISIT?	FOR POSITIVE ANSWERS, ADD COMMENTS HERE.
Constitutional : ☐ weight loss, fever, sweats, chills ☐ none	
Endocrine: ☐ recent issues with diabetes, cholesterol , thyroid ☐ none	
HEENT: ☐ ear, nose or throat problems, sleep apnea or daytime drowsiness, eye problems ☐ none	
Cardiovascular: ☐ chest pain, palpitations, new murmur, dizziness, shortness of breath, heart problems ☐ none	
Respiratory: ☐ breathing problems, wheezing, cough, infections ☐ none	
GI: ☐ problems swallowing, heartburn, rectal bleeding, change in stools, liver problems ☐ none	
Genitourinary: ☐ painful urination, frequency, blood in urine, waking up frequently to urinate, incontinence, stones, UTI'S ☐ none	
Musculoskeletal: ☐ arthritis, gout, neck pain, joint pain, severe back pain, or sciatica, fractures ☐ none	
Neurologic: ☐ TIA's, stroke, severe headaches, seizures, memory loss, memory issues, weakness, numbness, loss of balance ☐ none	
Hematologic: ☐ heavy bleeding, blood clots, excessive bruising, cancer or transfusions ☐ none	
Psych: ☐ depression, anxiety/panic disorder, psychosis, drug or alcohol issues ☐ none	
Skin: ☐ rashes, skin cancer, changing moles, chronic itching ☐ none	

Have you had any surgeries this year? If so, list surgery and date(s): _____

If you received the following vaccines since your last visit, please note the date(s):
Flu _____ **Shingles** _____ **Pertussis (whooping cough)** _____ **Tetanus** _____ **Pneumonia** _____
Other _____

YOU MAY ADD ANY CONCERNS YOU WISH TO SHARE HERE: