WELCOME
TO OUR PRACTICE!

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Date ____________ Soc. Sec. # ____________ Birthdate ____________

Name ____________ Last Name ____________ First Name ____________ Initial Home Phone ____________

Address ____________ Cell Phone ____________

City ____________ State ____________ Zip ____________ E-mail ____________

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer ____________ Business Phone ____________

Business Address ____________ Occupation ____________

Who should we thank for referring you? ____________

In case of emergency, who should we contact? ____________ Phone ____________

PRIMARY INSURANCE

Person Responsible for Account ____________ Last Name ____________ First Name ____________ Initial

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Responsible Party Employed By ____________ Business Phone ____________

Business Address ____________ Occupation ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I.D. # ____________ Group # ____________

ADDITIONAL INSURANCE

Insured Name ____________ Last Name ____________ First Name ____________ Initial

Relationship to Patient ____________ Birthdate ____________ Soc. Sec. # ____________

Address ____________ Home Phone ____________

City ____________ State ____________ Zip ____________

Insured Employed By ____________ Business Phone ____________

Insurance Company ____________

Insurance Company Address ____________

Subscriber I.D. # ____________ Group # ____________

PLEASE COMPLETE REVERSE SIDE

REASON FOR VISIT

Please list your present health concerns, problems or symptoms: ______

______

______

MEDICAL HISTORY

When was your last physical exam? ______

Physician's Name ______ Phone ______

1. Are you currently under medical treatment? ☐ Yes ☐ No
   Please describe: ______
2. Have you ever had any serious illnesses or operations? ☐ Yes ☐ No
   Please describe: ______
3. Are you currently taking any medication? ☐ Yes ☐ No
   Please describe: ______
4. Do you smoke? ☐ Yes ☐ No
5. Do you use alcohol? ☐ Yes ☐ No
6. Do you use cocaine or other drugs? ☐ Yes ☐ No
7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

Please describe: ______

8. Women Only:

	Yes	No
Do you have regular periods?	☐	☐
Are you taking birth control pills?	☐	☐
Have you ever been pregnant?	☐	☐

Number of Pregnancies: ______

Have you ever had the following:

	Yes	No		Yes	No		Yes	No
Anemia (low blood count)	☐	☐	Heart Murmur	☐	☐	Polio	☐	☐
Anorexia (no appetite)	☐	☐	Heart Disease	☐	☐	Prostate Problem	☐	☐
Arthritis	☐	☐	Hepatitis-Type ____	☐	☐	Psychiatric Care	☐	☐
Asthma	☐	☐	Hernia	☐	☐	Respiratory Disease	☐	☐
Back Problems	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Bleeding Tendency	☐	☐	High Blood Pressure	☐	☐	Scarlet Fever	☐	☐
Blood Disease	☐	☐	HIV/AIDS	☐	☐	Shortness of Breath	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Sinus Trouble	☐	☐
Chemical Dependency (addiction to drugs)	☐	☐	Kidney Disease	☐	☐	Skin Rash	☐	☐
Chemotherapy	☐	☐	Latex Sensitivity	☐	☐	Stroke	☐	☐
Chicken Pox	☐	☐	Liver Disease	☐	☐	Thyroid Problems	☐	☐
Chronic Fatigue Syndrome	☐	☐	Low Blood Pressure	☐	☐	Tonsillitis	☐	☐
Circulatory Problems	☐	☐	Measles	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesions	☐	☐	Migraine Headaches	☐	☐	Ulcer	☐	☐
Cough - persistent or bloody	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Mumps	☐	☐	Any Other Condition	☐	☐
Emphysema	☐	☐	Multiple Sclerosis	☐	☐	Please describe: ______		
Epilepsy	☐	☐	Pacemaker	☐	☐	______		
Glaucoma	☐	☐	Pneumonia	☐	☐	______		

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to W. B. HUMENIUK MD PA for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party ______ Date ______