## PATIENT INFORMATION

Last	First	Mildale
Name		Name
Preferred	Maiden	Preferred
Name		Pharmacy& Address
Date of	Social	PrimaryEnglish
Birth		Language Spanish
Marital	Driver's	
Status:	License State	#
Race:A	African AmericanAmerican IndianAsi	ianCaucasianHispanicOther
Religion: _	CatholicProtestantHinduIslam	JewishBuddhistOther
Address:	ZIP	City State
Primary	Work	Cell
Phone:	Phone	Phone
Fax	Pager	
Number		E-mail
<u></u>	Full	Part
Employer:	Time	Time
Phone	Hire	
Or Ext	Date	Occupation
Last Name	OR SPOUSE (Circle One) INSUREI First Name	Middle Name
Preferred	Maiden	
Name		The state of the s
Date of	Social	Primary English
	Security # Driver's	Language Spanish
Marital		to #
Status:	License Sta	ie
Address: _	ZIP	CityState
Primary	Work	Cell
Phone:	PhonePhone	Phone
Fax	Pager	
Number_		E-mail
	Full Par	rt
	Time Tim	ne
Phone	Hire	
Or Ext	Date	Occupation
EMERGI	ENCY CONTACT:	
Last	First	Middle
Name	Name	Name
Preferred	Maiden	Date of Birth
Name	Name	& Relationship
Address:_		CityState_
Primary	Work	Cell
Phone:	Phone	Phone

PATIENT MEDIC	CAL HISTORY - Please attach additio	nal pages if necessary	
Name:	_		
Surgical History			
Please list all su	rgeries you have had.	<u> </u>	1
	Procedure	Date	
	L		
<b>Current Medica</b>			
Please list all pr	escription, herbal, & over the counte	•	
	Medication	Dosage & Frequency	Prescribing Physician
Allanaina			
Allergies	nedications you are allergic to & read	ction	
rieuse list ully li	Medication	Reaction	
	Tricalcation	neuction	
Are you allergic	to Latex? Yes No		
Diago Por	ah an all anatas (for all and a constant)	ant vary leaves	
Please list any c	other allergies (food, environment) the	nat you nave:	
		•	
Menstrual Histo	ory (as applicable)		
	Age of Onset	/Date	e of last period
	Age of Menopause	Length of flow (days	
	Number of Pregnancies	Interval (days betwee	en periods)
	Number of Miscarriages	Multiple Births (Twins etc)	Yes No
	Number of Living Children	Number of Spontane	ous Miscarriages
	Number of Elective Abortions		

## PATIENT MEDICAL HISTORY - Please attach additional pages if necessary Name: **Currrent & Past Medical Diagnosis** Please list all medical conditions you have or have had diagnosed. Description Date or Age Diagnosed Current / Past Current \_\_\_\_ Past \_Current \_\_\_\_ Past Current \_\_\_\_ Past \_Current \_\_\_\_ Past Have you ever smoked? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, are you currently smoking? \_\_\_\_\_Yes \_\_\_\_\_ No Amount smoked per day \_\_\_\_\_ Do you drink alcohol? \_\_\_\_\_ Yes \_\_\_\_ Never \_\_\_\_ Occasionally If yes, number of drinks per week/month (circle one) \_\_\_\_\_ Have you ever used recreational/street drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, what kind? \_\_\_\_\_ **Family History** Please list any medical conditions of immediate family members Mother Father **Grandmother (Maternal) Grandfather (Maternal) Grandmother (Paternal) Grandfather (Paternal)** Aunts Uncles **Brothers**

Sisters

Patient Name:							
Patient HIPAA Questionnaire							
1	1.	Please list anyone whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).					
		Name	Phone #	Relationship to Patient			
	-	<del></del>					
	-						
2	2.	Please print the address you want your billing statements and/or correspondence from our office to be sent if other than your home.					
3	3.	We routinely leave messages (i.e. appointment reminders or requests to call our office back) on telephone answering machines or voicemail? If you do not want these messages handled in this fashion, indicate otherwise.					
Patient Signature (Guardian if under 18) Date							
IF THE PATIENT IS UNDER 18, AND NOT PREGNANT, A PARENT OR GUARDIAN MUST COMPLETE THE CONSENT TO TREAT BELOW:							
I am	the m	e parent/legal guardian of ny permission for Dr. Libso	on to provide complete r	who is a minor. medical care for her.			

Signed \_\_\_\_\_ Date \_\_\_\_

## **Patient Financial Policy**

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and Sign)

I hereby authorize Dr. David S. Libson to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. If I fail to provide the correct insurance or Medicaid/Medicare information to the office, I understand I will be responsible for any amount not paid or recouped by third party carriers.

information to the office, I understand I not paid or recouped by third party carr	will be responsible for any amount
Signature	Date
NEW POLICY ACKN	IOWLEDGEMENT
Effective October 15, 2018, there will be recouped by third party carriers) of \$40. and a \$20.00 for same day cancellations.	00 for a no show to your appointment
Signature	Date

1 of 2 9/15/2021, 3:33 PM