PATIENT INTAKE FORM

___Gregg Wolff, MD

Appointment date:_____
Appointment time:_____

Referred by:_____ Primary Care Physician_____

Patient Name:_____ **Age:**_____ **D.O.B.**_____
(last) (first) (middle)
Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone: ( )____-_____ **S.S.#:**_____-_____-_____ **Marital Status:** M S D W

Cell Phone: ( )____-_____ **E-Mail Address:**_____

Sex: Male/Female Height:_____ **Weight:**_____ **Employed:** Yes/No **Student:** Yes/No

Employer/School:_____ **Occupation:**_____
Address:_____ **Phone:** ( )____-_____

Person To Notify In Case of Emergency:_____
Address:_____ **Phone:**_____
Relationship To Patient:_____

Describe the reason for your visit:_____
Date of Injury or Onset of Pain:_____

Workers Compensation: Yes/No **Auto Accident:** Yes/No

Insurance Information:
Primary Insurance_____ **Phone:** ( )____-_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Policy Holder:_____ **I.D.#:**_____ **Group#:**_____

Secondary Insurance_____ **Phone:** ( )____-_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Policy Holder:_____ **I.D.#:**_____ **Group#:**_____

If Workers Comp or Auto Accident, Please List the Following:
Name of Insurance Agency:_____
Address:_____ **City:**_____ **State:**_____ **Zip:**_____
Policy Holder:_____ **Claim or Case #:**_____
Contact Person:_____ **Phone:** ( )____-_____ **Fax:** ( )____-_____

If unable to reach patient by phone, message may be left for patient to return call at
Home #: Yes/No **Work #:** Yes/ No **Other:**(please list)_____

MEDICAL HISTORY

Do you now have or have you ever had the following:

Heart Trouble _____	Yes/No	High Blood Pressure_____	Yes/No
Diabetes _____	Yes/No	Blood Disease_____	Yes/No
Abnormal Bleeding_____	Yes/No	Blood Transfusion_____	Yes/No
Epilepsy, Seizures _____	Yes/No	Jaundice_____	Yes/No
Liver Disease, Mono _____	Yes/No	Kidney Disease_____	Yes/No
Breathing Problems_____	Yes/No	Stomach Problems_____	Yes/No
Paralysis_____	Yes/No	Muscle Weakness_____	Yes/No
Numbness/Tingling_____	Yes/No	Arthritis_____	Yes/No

Please List Any Other Medical Problems:_____

_____

Please List Any Pertinent Family History:_____

_____

Possibility Of Pregnancy At This Time: Yes/No

Please List Allergies To Any Medications:_____

_____

Please List All Medications You Are Presently Taking Including Aspirin:_____

_____

Do You Smoke: Yes/No **How Much:**_____
Do You Drink: Yes/No **How Much:**_____

Please List All Previous Surgeries:_____

_____

_____

Please List Any Complications or Abnormalities Following Surgery:_____

_____

Signature Of Person Completing Form:_____
Relationship To Patient:_____
Doctor's Signature:_____ **Date:**_____

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