

Getting to Know You

Patient Name _____ Date _____
Last First Middle

Address _____ City _____ Zip _____

Phones () _____ () _____ Email Address _____
Home Cell

Sex (M) (F) Age _____ Date of Birth _____ Marital Status (S) (M) (D) (W)

Social Security No. _____ Parent Social Security No. _____

Occupation _____ Employed by _____ Phone _____
work

Employer's Address _____ City/State _____

Name of Spouse/Parent/Friend _____ Phone _____

Employer _____ Phone _____
work

Address _____ City/State _____

Primary Care Physician/Pediatrician _____ City/State _____

Phone _____

Reason for visit today _____

Referred to Dr. Epstein by: _____

Medicare # _____

Insurance Company _____ Group # _____

Primary Insured's Name _____ Date of Birth _____ Policy # _____

Patient appointments that are cancelled less than 24 hours in advance or
no show appointments will be charged a \$40.00 fee.

I hereby authorize Dr. Epstein to release any information acquired in the course of my examination.

I agree that medical photographs may be taken in the course of treatment.

I agree that photocopies of this form will be as valid as the original

I agree that any balance not covered by my insurance will be paid by me.

Balances unpaid after 30 days from date of service are subject to a service charge of 1 ½% per month.

Today's Date

Signature of Patient or Guardian

Medical History

1. Are you in good general health? Yes No
2. Are you subject to prolonged bleeding or delayed healing? Yes No
3. Have you had any serious illnesses or operations? Yes No

If yes, please list with year _____

Do you have a History of any of these conditions? Yes No
If yes, please circle which conditions:

- | | | | |
|---------------------|----------------------|-----------------------|-----------------------|
| Diabetes | Asthma | Bleeding Disorders | Alzheimer's |
| Gout | Epilepsy | Arthritis | Depression |
| High Blood Pressure | Eye Disease | Rheumatic Fever | Psychiatric Disorders |
| Heart Disease | Stomach Ulcers, etc. | Circulatory Disorders | Addictions |
| Kidney Disease | Liver Disease | Respiratory Disorders | HIV/Aids |

Do you have any Allergies to medications? Yes No
If yes, please circle which medications:

- | | | | | |
|------------|-------------------|--------|---------|---------|
| Penicillin | Local Anesthetics | Iodine | Aspirin | Tetanus |
| Codeine | Tape | Sulfa | Demerol | |

Other Allergies _____

List Medications and give dosage

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Pharmacy _____ Address _____

Endocrinologist _____ Address _____

Cardiologist _____ Address _____

Authorized Representative Form

I understand that your general policy is not to disclose my personal health information to other parties, except those directly involved in my care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my personal health information to the person(s) named below for the purpose of assisting with, or facilitating, the coordination of my health care.

Authorized Representative #1

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

Authorized Representative #2

Name: _____ Phone Number: _____

Address: _____

Relationship to You: _____

I also authorize Dr. Epstein's Office to leave voice messages confirming upcoming office visits.

I have had full opportunity to read and consider the content of this Authorized Representative Form. I understand that, by signing this form, I am confirming my authorization that Dr. Epstein may use and/or disclose my personal health information to the above named person(s).

Signature: _____ Date: _____