

**Referring Doctor:** \_\_\_\_\_

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.				
Name:		Nickname:	Today's date	
Address:		City/State	Zip	Chart #
AGE:	SSN:	Birthdate:	Marital Status:	Gender:
Home Ph:		May we contact you here?	May we leave a message ?	
		YES	NO	YES
Work Ph/Ext :		YES	NO	YES
		YES	NO	YES
Cellphone:		YES	NO	YES
		YES	NO	YES
Fax:		YES	NO	YES
		YES	NO	YES
Email:		YES	NO	YES
		YES	NO	YES
Occupation:		Employer:		
Address:				
Spouse's Name, Occupation and Employer				
Emergency Contact Name:			Relationship:	
ER Contact Home Ph:		ER Contact Work Ph:		
<u>If patient is a minor:</u>	Father's Name:	Work Phone		
Father's Employer:				
Mother's Name:		Work Phone:		
Mother's Employer:				

**PAYMENT FOR OFFICE VISITS OR OFFICE PROCEDURES IS REQUIRED AT THE TIME OF THE APPOINTMENT. WHEN POSSIBLE AN ESTIMATE OF THE CHARGES INVOLVED WILL BE GIVEN AND YOU WILL BE PROVIDED A RECEIPT FOR FILING WITH YOUR INSURANCE.**

<b>Primary Insurance Co:</b>		
Insured Party:	ID No:	Group No:
Ins Company Address:		
<b>Secondary Insurance Co:</b>		
Secondary Insured Party:	ID No:	Group No:
Ins Company Address:		

**PLEASE PROVIDE COPIES OF INSURANCE CARDS**

**OVER**

**MEDICAL INFORMATION**

**PATIENT NAME:** \_\_\_\_\_

**REASON FOR OFFICE VISIT TODAY (PLEASE BE SPECIFIC)** \_\_\_\_\_

**REFERRED BY (NAME OF PHYSICIAN OR FRIEND)** \_\_\_\_\_

**IF INJURED, DATE OF INJURY** \_\_\_\_\_ **DID THIS OCCUR AT WORK?** \_\_\_\_\_

**HAVE YOU SEEN DR. MANUEL OR DR. COLE BEFORE?** \_\_\_\_\_

**IF SO, WHEN?** \_\_\_\_\_

**NAME OF USUAL PHYSICIAN** \_\_\_\_\_

**PAST SURGERY** \_\_\_\_\_

**KNOWN MEDICAL PROBLEMS (IF NONE , WRITE NONE)** \_\_\_\_\_

**DO YOU SMOKE CIGARETTES OR USE TOBACCO PRODUCTS? YES( ) NO( )**

**HAVE YOU BEEN TESTED FOR THE HIV (AIDS) VIRUS? YES( ) NO( )**

**RESULTS** \_\_\_\_\_ **DATE OF TEST** \_\_\_\_\_

**TO YOUR KNOWLEDGE HAVE YOU BEEN EXPOSED TO HIV? YES( ) NO( )**

**I HEREBY AUTHORIZE DR. MANUEL AND DR. COLE OR THE OFFICE STAFF TO TAKE AND MAINTAIN PRE & POST OPERATIVE PHOTOGRAPHS AS A PART OF MY MEDICAL CHART.**

**SIGNATURE OF PATIENT OR GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PATIENT NAME** \_\_\_\_\_

**DATE** \_\_\_\_\_

**Medication ALLERGIES: please check**

\_\_\_\_\_ **I have no medication allergies**

\_\_\_\_\_ **I have medication allergies. Please list and describe what happens:**

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**What medications do you take? (include aspirin, non prescription medications, vitamins and natural pathic medications )**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_
12. \_\_\_\_\_

**Other:**

**ASSIGNMENT AND RELEASE**

*I hereby irrevocably authorize my insurance company/fund to pay benefits for services directly to Michael D. Manuel, M.D. if I have not paid in full myself. Furthermore, I understand **that I am financially responsible for any amount not paid by my insurance company.** I also authorize Dr. Manuel to release any information required to process a claim, including but not limited to insurance companies, health care service plans, worker's compensation carriers and government services.*

**PATIENT'S**  
**SIGNATURE:** \_\_\_\_\_

**DATE** \_\_\_\_\_

**IF PATIENT IS A MINOR:**

**PARENT/GUARDIAN**  
**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

**RELATIONSHIP TO**  
**MINOR** \_\_\_\_\_

**PRIVACY**

I understand the Federal Government has placed restrictions on the exchange/release of patient medical information. In cooperation with these new regulations and to facilitate better and more rapid exchange of information, I offer consent to the release of information to other treating physicians or health care providers, hospitals, my insurance company (or other payers). I understand this information may be exchanged via mail, fax, other electronic media (e-mail), telephone or orally. **All attempts will be made to keep this information STRICTLY confidential.**

**PATIENT'S**  
**SIGNATURE:** \_\_\_\_\_

**DATE** \_\_\_\_\_

**IF PATIENT IS A MINOR:**

**PARENT/GUARDIAN**  
**SIGNATURE** \_\_\_\_\_

**DATE** \_\_\_\_\_

**RELATIONSHIP TO**  
**MINOR** \_\_\_\_\_