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PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY (Use Black Ink Pen)

Patient Last Name ______________________ First Name ____________________ Middle Initial ______

Address ____ Apt # __________

City ______________________________________ State ________ Zip ______________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

Pharmacy Phone: ________________ Fax Number: ________________ Email: ________________

Date of Birth: ______________ Age: _____ Gender (F) ____ (M) ____ Marital Status:(S)___ (M)___ (D)___ (W)___

Social Security Number: __________________

Name of Employer: ______________________________ Occupation: ____________________

Business Address: ____

Emergency Contact ________________ Phone# ______________ Relationship __________________

MAY WE LEAVE A MESSAGE ON YOUR: ( ) HOME PHONE ( ) ANSWERING MACHINE ( ) CELL PHONE

PRIMARY INSURANCE: ***(PLEASE PROVIDE INSURANCE CARD(S) TO BE PHOTOCOPIED)***

Primary Insurance Holder :(Person to be billed if not patient) Patient ( ) Spouse ( ) Parent/ Guardian ( )

Name of Policy ____

Claims Mailing Address ____

Patient ID. No. ____________________ Group No. ____________________

Date of Birth ______________ Social Security No. ____________________

SECONDARY INSURANCE: *(PLEASE PROVIDE INSURANCE CARD(S) TO BE PHOTOCOPIED)*

Secondary Insurance Holder :(Person to be billed if not patient) Patient ( ) Spouse ( ) Parent/ Guardian ( )

Name of Policy ____

Claims Mailing Address ____

Patient ID. No. ____________________ Group No. ____________________

REFERRING PHYSCIAN INFORMATION

Last Name ______________________ First Name ______________________ Middle Initial _____

Address ____ Apt # __________

City __________________________ State _____ Zip Code _______ Telephone No. ______________

Is this the Primary Care giver (Y) (N) If not, please provide the name of your PCP: ____________________

PATIENT MEDICAL HISTORY

ALLERGIES: (list all allergies including medications, food latex, etc, and their reaction)

____

CURRENT MEDICATIONS: (list all medications including the dosage and frequency of use. Include and vitamins supplements over the counter medications and herbals) ____

____

____

I authorize the release of medical information which could include HIV status, communicable disease or drug abuse information to and from my primary care and referring physician(s) outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to the physicians DANIEL J. ADLER, M.D, P.C.. By signing this form, the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand this it is my responsibility to inform the organization of such changes. I have reviewed and understand, and a copy of the following information has been made available to me: **Information regarding the ownership of the practice; the expertise of the associated physicians; the Patient Rights and Responsibilities; the Patient Grievance Process; DNR policy; Notice of Privacy Practice.**

______________________ ______________________ ______________

Signature of Patient or Responsible Party | Printed Name | Today's Date

Daniel J. Adler, M.D., P.C.

UNIVERSAL MEDICATION FORM

Fold this form and keep it in your wallet **Date form started:**

Name:	**Allergies:**
Phone Number:	
Birth Date:	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: 1) Prescription and over-the-counter medications (examples: aspirin, antacids) herbals (examples: ginseng, gingko), and vitamins. Include medications taken as needed (example: nitroglycerin). Please also include if you received any injections recently, i.e. steroids. 2) CROSS OFF any medications you no longer take. 3) Keep this card with you at all times. Show this card to every doctor visit on every visit, every visit to an emergency room and on admission to any hospital. 4) NEVER take drugs prescribed for someone else.

DATE PRESCIBED	NAME OF MEDICATION / DOSE	DIRECTIONS: (How many times a day do you take this and when.)	Medication held due to procedure		DATE STOPPED	Notes/ Instructions
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		
			Yes	No		

Patient Signature ______________________________ Date_______

Signature of representative of organization accepting the patient________________________________ Date_______

Updated: (List all dates updated)

Patient/Guardian Signature Date

Patient/Guardian Signature Date

Organizational Representative Signature Date

Organizational Representative Signature Date