ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name_____________________________Birthdate________________Soc.Sec. #___________________

Phone (______)_____________Other dependents covered ____

Insurance Company____ Soc. Sec. #____________________

Contract #_______________________ Group # _______________________Subscriber #_____________________

MEDICAL HISTORY

Physician's Name _______________________________________Date of Last Visit__________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combination of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
☐ Yes ☐No

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? ☐ Yes ☐ No If so, which drug? ____

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe______________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give dates__________________________________

(Women) Are you Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Back Problems
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ HIV/AIDS
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease

MEDICATIONS

List any medications you are currently taking

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ALLERGIES

____

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SIGNATURE:____ DATE: ____________________