HEALTH HISTORY UPDATE

Patient Name: _____ D.O.B: _____

Home Address: _____ Height: _____

Home/Cell Phone #: _____ Weight: _____

Email Address: _____ Current Smoker: ___Yes ___No

Primary Care Physician: _____

Health Insurance Company: _____

Has there been any changes in your health since your last visit? If Yes, please explain. ❑ No Changes

_____

_____

Has there been any changes in your medications since your last visit? If yes, please list. ❑ No Changes

_____

_____

Do you have any new allergies to medications since your last visit? If yes, please list medication and reaction. ❑ No Changes

_____

Are there any new illnesses, hospitalizations, surgeries, or problems since your last visit? If yes, please explain: ❑ No Changes

_____

_____

_____

Is this visit related to a motor vehicle accident or work injury? ❑ Yes ❑ No

_____ _____

Patient/ Parent/Legal Guardian Signature Date

Cancellation Policy: I agree to pay a $50 fee for any appointment cancelled less than 24 hours prior to my appointment time and a $75 fee for any missed appointment.

Assistant Surgeon Fee Disclosure:

If a Surgical procedure requires the use of an assistant, the patient acknowledges and agrees that a fee of $350 will be charged for the assistant's services. This fee may not be covered by insurance and, if not covered, the patient agrees to be financially responsible for payment.