Medical Insurance and Past Medical History

NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH	
STREET ADDRESS		CITY		STATE	ZIP CODE

Emergency Contacts

PARENT'S NAME	HOME PHONE	WORK PHONE
SECONDARY CONTACT	HOME PHONE	WORK PHONE
OTHER CONTACT	HOME PHONE	WORK PHONE

Insurance Information

(Attach copy of insurance card)

PERSON RESPONSIBLE FOR PAYMENT		HOME PHONE	WORK PHONE
STREET ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	EMPLOYER		
INSURANCE COMPANY	POLICY HOLDER	POLICY #	GROUP #

Medical History

(Check any of the items listed below that apply to you now or in the past.)

___ ANEMIA
___ CHICKEN POX
___ CONVULSIONS OR SEIZURES
___ DIABETES
___ FAINTING SPELLS
___ NOSE BLEEDS
___ FREQUENT OR SEVERE HEADACHES
___ HAY FEVER OR ASTHMA
___ HEART MURMUR
___ HEPATITIS
___ IDENTITY FREQUENTLY USED RX/DOSAGE ___
___ SLEEPING DISORDERS
___ KIDNEY TROUBLE
___ MENTAL RETARDATION
___ MONONUCLEOSIS
___ STOMACH OR ULCER
___ OTHER ___

Allergic Reactions

	Identify Medicine, Food, insect, etc.	Describe Reaction
___ MEDICATIONS	___	___
___ ANY FOODS	___	___
___ INSECT BITES OR STINGS	___	___
___OTHER	___	___

HOSPITALIZATIONS: List all illness, surgery, or psychiatric therapy beginning with the most recent.

DATE	REASON	HOSPITAL	PHYSICIAN

MEDICAL HISTORY: List all illness, surgery, or psychiatric therapy beginning with the most recent.

DATE	ILLNESS/PROCEDURE	TREATMENT FACILITY	PHYSICIAN