

PATIENT INFORMATION, MEDICAL HISTORY & LIFETIME SIGNATURE

DATE _____ S/S# _____ EMAIL ADDRESS _____
 NAME _____ HOME PHONE _____ CELL _____
 ADDRESS—Street: _____ APT# _____
 CITY: _____ STATE: _____ ZIP: _____ AGE: _____ BIRTH DATE: _____
 Check appropriate box: Male Female Minor Single Married Divorced Widowed Separated
 Patient's or Parent/guardian's employer: _____ Work Phone: _____
 Business Address _____ City _____ State _____ Zip _____
 Occupation _____ In case of an emergency contact _____ Phone _____
 Person responsible for this account _____ Relationship to patient _____
 Drivers License# _____ Is this person currently a patient in this office? ___ Yes ___ No

***INSURANCE INFORMATION**

NAME OF Primary INSURANCE CO. _____ Policy# _____ Group# _____
 Name of Insured _____ Relationship to pt. _____ Insured D/O/B _____ SS# _____
 Insurance Co. address _____ City _____ State _____ Zip _____
 Name of Employer _____ Address of Employer _____
 City _____ State _____ Zip _____ Phone# _____
 How much is your deductible? \$ _____ How much have you used? \$ _____ Co. Pay Amount \$ _____

Do you have any additional insurance? Yes No **If yes, complete the following**

NAME OF 2nd INSURANCE CO. _____ Policy# _____ Group# _____
 Name of Insured _____ Relationship to pt. _____ Insured D/O/B _____ SS# _____
 Insurance Co. address _____ City _____ State _____ Zip _____
 Name of Employer _____ Address of Employer _____
 City _____ State _____ Zip _____ Phone# _____
 How much is your deductible? \$ _____ How much have you used? \$ _____ Co. Pay Amount \$ _____

Please answer "YES" or "No" to the following questions:

Were you injured on the job? _____ If yes date of injury _____ Are you covered under Workers Comp? _____
 Were you involved in an auto accident? _____ If yes date of injury _____ Are you covered by Auto Ins.? _____
 Do you have an Attorney? _____ Attorney Name _____ Attorney Phone # _____

How did you come to this office? (Please check appropriate box) Ins. Company/Book
 Newspaper Radio TV Magazine Web Florida Panthers Bank Atlantic Center
 Yellow Pages Friend /Patient _____ Physician _____ Other _____

MEDICAL HISTORY

Patient Name _____ Pt. D/O/B _____ Chart # _____

What are we seeing you for:

Name of Current Physician _____ Phone Number _____	Name of Current Physician _____ Phone Number _____
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Have you ever had the following: (Circle "NO" or "YES")

Pneumonia	NO	YES	Migraine Headache	NO	YES	Hives/Eczema	NO	YES
Cancer	NO	YES	Tuberculosis	NO	YES	AIDS	NO	YES
Asthma	NO	YES	Diabetes	NO	YES	HIV+	NO	YES
Arthritis	NO	YES	Bleeding Tendency	NO	YES	Infectious Mono	NO	YES
Anemia	NO	YES	Nose Bleeds	NO	YES	Stroke	NO	YES
Epilepsy	NO	YES	High Blood Pressure	NO	YES	Hepatitis A	NO	YES
Sinusitis	NO	YES	Visual Problems	NO	YES	Hepatitis B	NO	YES
Hearing Loss	NO	YES	Rheumatic Fever	NO	YES	Hepatitis C	NO	YES
Tonsillitis	NO	YES	Heart Disease	NO	YES	Thyroid Disease	NO	YES
Hoarseness	NO	YES	Mitral Valve Prolapse	NO	YES	Kidney Disease	NO	YES

Any other disease please list: _____

Please list all CURRENT MEDICATIONS you now take (include non-prescription): _____

When did you last use ASPRIN/ANTI-INFLAMMATORY medicine? _____

Please list any and all "ALLERGIES TO MEDICATIONS": _____

Previous Hospitalization / Surgeries / Serious Illnesses:

_____ When _____
 _____ When _____

FAMILY HISTORY: (Circle "NO" or "YES")			Family Member			Family Member		
Heart Disease	NO	YES	Stroke	NO	YES			
Cancer	NO	YES	Diabetes	NO	YES			
Asthma	NO	YES	High Blood Pressure	NO	YES			
Arthritis	NO	YES	Thyroid Disease	NO	YES			
Anemia	NO	YES	AIDS	NO	YES			
Epilepsy	NO	YES	HIV+	NO	YES			
Hearing Loss	NO	YES	Hepatitis A, B, C	NO	YES			

PATIENT SOCIAL HISTORY:

Use of Alcohol: Moderate _____ Rarely _____ Never _____ Use of Tobacco: How Much? _____ Prev., but Quit on _____ Never _____

Use of Drugs: Type/Frequency _____ Never _____

Authorization To Release Medical Information & Assignment of Insurance Benefits

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim, I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services. I understand that I am responsible for (a) any amounts applied to the deductible, as well as the 20% Co-Insurance and any non-covered services under the Medicare Program; and (b) for charges not paid by my Insurance. This authorization in no way relieves me of the responsibility of making payment to Tartell & Mandel, M. D., LLC, and any other costs incurred in the process of securing payment in the event that they should not receive any payment from my insurance company.

DATE: _____ SIGNATURE (Patient or Parent/Guardian): _____