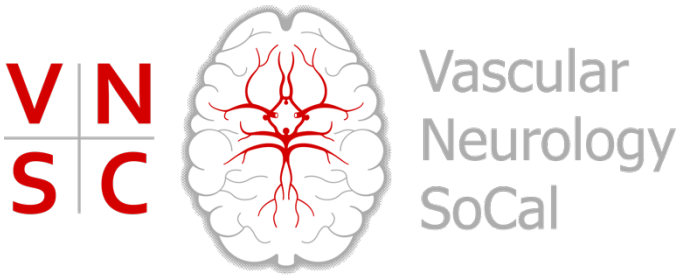

Ph: 805.242.4884 | Fax: 805.242.4885

New Patient Information

Please provide your insurance information to the receptionist.

First Name:	**Last Name:**
DOB:	**Gender:** [ ] Male [ ] Female
Address:	**City:** **Zip Code:** **State:**
Home Phone: ( )	**Cell Phone: ( )**
Social Security #:	**Email:**
Emergency Contact:	**Relationship:**
Phone Number: ( )	**Email:**
Preferred Pharmacy:	**Phone Number:**
Address:	**City:** **Zip Code:**

Health Questionnaire

Please list all physicians involved in your care below:

Primary Care:	**Phone:**
Cardiologist:	**Phone:**
Ophthalmologist:	**Phone:**
Neurologist:	**Phone:**
Other:	**Phone:**
Other:	**Phone:**
Other:	**Phone:**

Please list any drug allergies down below, if none write NKDA:

Allergy	**Mild, Moderate, or Severe?**

Please check any of those that apply to you:

Angina		**Neuropathy**		**Asthma**		**Bleeding Disorder**		**Weakness**	
Epilepsy/ Seizures		**Congestive Heart Failure**		**High Cholesterol**		**Thyroid Disorder**		**GERD/ Reflux**	
Headaches		**Stroke**		**Depression**		**Osteoarthritis**		**Anxiety**	
Multiple Sclerosis		**Liver Disease**		**Kidney Disease**		**Pacemaker/ Defibrillator**		**Arthritis**	
Diabetes		**High Blood Pressure**		**Heart Attack**		**Anemia**		**Numbness**	
Tingling		**Cancer**		**Dizziness**					

Past Surgical History:

Type of Surgery	Year	Surgeon

Social History:

Do you smoke? _____ Yes _____ No
Have you ever smoked? _____ Yes _____ No
Do you drink alcohol? _____ Yes _____ No
Do you have a history of substance abuse? _____ Yes _____ No

Please list all medications that you are currently taking:

Medication/ Dosage	Frequency

If you have a medication list please ask the receptionist to make a copy for our records.

I certify that all the information has been competed to the best of my knowledge.

Patient Signature: _____Date: _____