Today's date:	Reason for Visit:

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Married / Divorced / Separated / Widow

Is this your legal name?		If not, what is your legal name?	Nickname or name you wish us to refer to you by:	Birth date:	Age:	Sex:	
❑ Yes	❑ No			/ /		❑ M	❑ F

Address:	City:	State:

ZIP Code:	Email Address:	Home Number:	Cell Number:

Social Security Number:	Employer:	Preferred Method of Contact:

Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital	❑ Family	❑ Friend
❑ Close to home/work	❑ Yellow Pages	❑ Other	Name of Family/Friend:		
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /		Address (if different):		Home phone no.: ( )
Is this person a patient here?	❑ Yes	❑ No	Is this patient covered by insurance?	❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Primary Insurance Name:

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary Insurance Name: (if applicable):	Subscriber's name:	Birth date:	Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I also authorize Waterfalls Longevity Center or insurance company to release any information required to process my claims. **I understand and agree that the staff is not routinely available outside of regular hours of operation. I understand that during such times it would be necessary for me to obtain emergency medical care at another health care facility, at an urgent care clinic, or at a hospital emergency room.** I understand that I am financially responsible for all fees and charges rendered at the time of service.

Patient/Guardian signature:	Date:

MEDICAL HISTORY

Condition/Illness:	Date Began:	Provider Seen:
1. ________	1. ________	________
2. ________	2. ________	________
3. ________	3. ________	________
4. ________	4. ________	________
5. ________	5. ________	________
6. ________	6. ________	________

PAST HEALTH HISTORY

Have you been:			
Hospitalized in the last 5 years?	❑ No	❑ Yes	
Do you smoke or use tobacco products?	❑ Never	❑Former Use	❑ Current use
Do you consume alcohol?	❑ Never	❑Former Use	❑ Current use

SURGERY(S)/ALLERGIES

Surgery:	Year:
1. ________	________
2. ________	________
3. ________	________
4. ________	________
5. ________	________
6. ________	________

Allergies (Food, environmental and/or medications):	Reaction:
1. ________	________
2. ________	________
3. ________	________
4. ________	________
5. ________	________
6. ________	________

MEDICATIONS

Currently taking including vitamins, herbs, minerals and other over-the -counter remedies

Date Started:	Medication and Strength:	Frequency:	Prescribing Physician: