

DANIEL L. BOSS, M.D.

NEW PATIENT INFORMATION

DATE: _____ E-MAIL ADDRESS _____

Patient's Name: _____ SS# _____

Sex ____ Age ____ Date of Birth _____ Marital Status S ____ M ____ W ____ D ____

Local Address: _____ Phone: _____

(City) (State) (Zip) Cell Phone _____

Out of state address: _____ PHONE _____

Patient's Employer: _____ Occupation _____

Employer's Address: _____ Bus Phone _____

Spouse Name: _____ SS # _____

Spouse Employer: _____ Occupation _____

Employer Address: _____ Bus Phone _____

Nearest Relative (not living in household) _____

Address: _____

Illness or Injury related to: Work ____ Auto Accident ____ Other ____

INSURANCE INFORMATION:

MUST HAVE INSURANCE CARD

PRIMARY LANGUAGE SPOKEN: _____

DO YOU HAVE A LIVING WILL (ADVANCED DIRECTIVES) Yes ____ No ____
TELL US IF YOU WANT ONE.

AUTHORIZATIONS:

I hereby authorize Dr. Boss. to release any information acquired in the course of my treatment to my insurance company. I request that payment of authorized benefits be made either to me or on my behalf for any services furnished me by Dr. Boss (MEDICARE PATIENTS) I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

DATE: _____ SIGNATURE: _____

YOUR MEDICAL HISTORY

The Doctor would like to know your past medical history in order to understand how he can help you. The information you give on this form will be kept confidential, for our files in this office only. The information will not be released to anyone else, unless you request the release in writing.

NAME _____ DATE _____

REFERRED BY _____

1. When was your last medical checkup? _____

Why are you here to see the Doctor today?

2. Have you been hospitalized or had surgery in your lifetime? Yes _____ No _____

FOR WHAT?

WHEN?

_____ MONTH YEAR

_____ MONTH YEAR

_____ MONTH YEAR

3. Have you had any other illnesses or injuries during your lifetime?

WHAT ILLNESS?

WHEN?

_____ MONTH YEAR

_____ MONTH YEAR

_____ MONTH YEAR

4. Medications _____

5. Allergies _____

NAME: _____

Health Maintenance:

Do you take Aspirin? Yes _____ No _____

Have you had a colonoscopy? Yes _____ No _____ When? _____

Have you had the Pneumonia vaccine (Pneumovax) Yes _____ No _____ When? _____

Have you had a mammogram? (if **female**) Yes _____ No _____ When? _____

Have you had a breast exam? (if **female**) Yes _____ No _____ When? _____

Date of last gynecologic exam? (if **female**) _____

Date of last Digital Rectal Exam? (if **male**) _____

Have you had a PSA? (if **male**) Yes _____ No _____ When? _____

SOCIAL HISTORY: Do you have regular exercise habits? Yes ____ No ____.

Do you sleep regularly? Yes ____ No ____ . Eat well-balanced meals? Yes ____ No ____.

A. Do you smoke? ____ How Long? ____ How Much? _____

B. Have you ever smoked? ____ When did you quit? _____

C. Do you drink? ____ How Much per week? _____

FAMILY HISTORY:

Mother living? ____ age ____ (or) died at age ____ Cause _____

Father living? ____ age ____ (or) died at age ____ Cause _____

Brothers living? ____ # deceased ____ age at death ____ Cause _____

Sisters living? ____ # deceased ____ age at death ____ Cause _____

Does anyone in your immediate family have heart disease, diabetes or cancer? _____

If so, please explain _____

When form is completed, Save the document on your computer and attach it to an e-mail and send it to:

INTMED@BELLSOUTH.NET

Thank you.