

Patient information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt# City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Any restrictions for contacting you? No Yes | Email _____

Contact Restrictions _____ | Sex Female Male

Age _____ Birthdate ____ / ____ / ____ SS# ____ - ____ - ____

Marital Status Single Married (Spouse's Name) _____

Patients Employer _____ Occupation _____
(If minor parents)

Address _____
Street City State Zip

Emergency Contact
(If minor parents info.)

Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell/Other Phone _____

Address _____
Street & Apt # City State Zip

How did you hear about us?

- Physician: _____ Family Member/Friend: _____
- Magazine: _____ Hospital: _____ Newspaper Ad: _____
- Yellow Pages: _____ Internet: _____ TV: _____
- Other: _____ I am a former patient

Do you have Medicare Part B coverage? Yes No If Yes, Medicare # _____ Effective Date _____

Is Medicare Primary or Secondary ?

I HEREBY AUTHORIZE DRs. BAXT TO RELEASE MY MEDICAL INFORMATION TO MY INSURANCE COMPANY, IF REQUESTED.

Signature, if minor, signature of Parent or Guardian Date

I HEREBY AUTHORIZE THE TAKING OF PHOTOGRAPHS BY THE DRs. BAXT OR THEIR REPRESENTATIVE FOR TREATMENT PURPOSES.
SIGNATURE _____ DATE: _____

If patient is a minor (under age 18), parent or guardian please sign below:
I give permission for _____ to receive treatment from
Name of Patient
Drs. Baxt _____
Signature of Parent or Guardian

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENT. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES. IT IS OUR POLICY TO RECEIVE PAYMENT FOR SERVICES WHEN RENDERED.

PLEASE COMPLETE REVERSE SIDE.

What are you consulting the doctor for today? _____

Do you have any allergies or sensitivities to medications? yes no

If yes, please list _____

Are you taking any medications at the present time? yes no

(This includes aspirin, sleeping pills, tranquilizers, high blood pressure medicine, and all topical medications used to treat any dermatological condition)

Please list all medications: _____

Recent Surgery/Treatments? yes no

Please List: _____

Are you planning a pregnancy? yes no Are you breast feeding? yes no Are you pregnant? yes no

Have you had a problem with general or local anesthesia? yes no

Are you on any form of restricted diet? yes no If so, please state: _____

Have you been treated with chemical peels, laser or accutane? yes no

If yes, please state: _____

Name of Internist or Family Physician: _____

PERSONAL & FAMILY RECORD					Please Indicate if you currently have the following by checking (✓) the condition below.										
Check (✓) condition(s) for self or if any blood relative has or has had any of the conditions listed below.															
	SELF		FAMILY MEMBER			SELF		FAMILY MEMBER		Y	N	Y	N		
	YES	NO	YES	NO		YES	NO	YES	NO						
Alcoholism					Keloid Scarring					Skin Problems			Wheezing or Shortness of Breath		
Anemia					Kidney Disease								Chest Pain/Heart Disease		
Arthritis					Leukemia								Heart Murmur		
Asthma					Liver Disease					Recent Weight Change			Irregular Heartbeat		
Birth Defects					Migranes					Fatigue/Weakness			Swollen Legs or Feet		
Bleeding Tendency					Mitral Valve Prolapse					Fever			Abdominal (Stomach) Pains		
Cancer					Multiple Sclerosis					Vision Problem/Eye Disease			Heartburn or Ulcer		
Cold Sores/Fever Blisters					Rheumatic Fever					Nose/Throat Problem			Gallbladder/Liver Disease		
Colitis					Skin Cancer					Hearing Problems/Ear Disease			Change in Bowel Habits (including blood in stool)		
Depression/ Nervous Condition/ Mental Illness					Thyroid					Frequent Headaches			Blood Disorder		
Diabetes					Tuberculosis					Depression			Easy Bleeding or Bruisability		
Emphysema					Varicose Veins					Thyroid Hormone Problems					
Epilepsy										Change in Appetite or Thirst					
Glaucoma					OTHER CONDITIONS:(PLEASE LIST)										
Hay Fever/ Sinus Problems															
Heart Attack															
Heart Disease					Do You: If Yes, daily consumption										
Hepatitis					Smoke					Pkgs.					
High Blood Pressure					Drink Coffee/Tea					Cups					
Pacemaker / Defibrilator					Liquor					OZS.					

I HEREBY ACKNOWLEDGE THAT ALL OF THE ABOVE INFORMATION HAS BEEN ANSWERED HONESTLY AND TO THE BEST OF MY ABILITY. I WILL UPDATE THE DOCTOR WITH ANY MEDICAL CHANGES THAT MAY OCCUR.

SIGNATURE: _____ DATE: _____