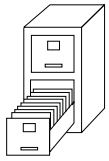
Today's Date _____

PATIENT QUESTIONAIRE
(for our records)
Please Print
Please answer ALL questions



Patient Information

Patient Name _____ Sex: M ☐ F ☐
Address _____
City _____ State _____ Zip _____ - _____
Marital Status _____ Age _____ Birth Date _____
Home Phone # _____ Work # _____ Ext _____ Cell # _____
Best place to reach you: Home ☐ Work ☐ Cell ☐
May we leave a message? Yes ☐ No ☐ E-mail address: _____
SS# _____ Occupation _____ Employer _____
Other Family Members who are patients of Dr. Johnson? > Names _____
Primary Care Physician _____

Financial Information

Person Financially Responsible _____ **Signature** _____
Name of Primary Insured _____ Relationship _____
Address _____
Name/Address/Phone # of Employer _____
Medical Insurance Co. _____
I.D. # _____ Group # _____
Medicare # _____ Primary Insured D.O.B. _____
SS # _____ Form of Payment: Cash ☐ Check ☐ MC/VISA ☐ Insurance ☐

Emergency

Who to Contact in case of an Emergency: Name _____
Home Phone # _____ Work # _____ Cell # _____
Address _____

Referral

Who referred you to Dr. Johnson? Doctor / Other Professional _____
Family member/Friend(name) _____
Sign ☐ Phone Book ☐ Internet ☐ Other ☐ _____

Medical History

Current Problem _____
Location _____ How Long? _____
Previous Treatments _____
ALLERGIES OR SENSITIVITIES?
Penicillin ☐ Tetracycline ☐ Sulfa ☐ Codeine ☐ Other Antibiotic/Med. ☐ _____
Novocaine or Local Anesthetic ☐ Any Other Allergies _____
HAVE YOU EVER HAD? High Blood Pressure ☐ Diabetes ☐ Ulcer ☐ TB ☐
Psychiatric Disorder ☐ Osteomyelitis ☐ Glaucoma ☐ Pacemaker ☐
Bleeding Disorder ☐ Kidney disease ☐ Heart or Heart Valve Disease ☐
Previous X-Ray Treatment ☐ Previous Skin Cancer ☐ Other Cancer or Tumors ☐
DO YOU HAVE A FAMILY HISTORY OF: Eczema ☐ Hives ☐ Allergies ☐ Hay Fever ☐
Details _____
Tobacco Use ☐ Packs per day _____ Alcohol Use ☐ _____
Please list below all medications you are taking (incl. over the counter) _____

_____

_____

_____ Birth Control Pills (females)? ☐