PALMS
ACUPUNCTURE
&
WELLNESS
JUPITER FLORIDA

Medical In-Take Form

Personal Information

TODAY'S DATE _____

FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ LAST 4 DIGITS OF YOUR SOCIAL SECURITY # _____

EMAIL ADDRESS _____ PHONE NUMBER _____ GENDER ◯ MALE ◯ FEMALE

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP TO YOU _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

Person Responsible For Payment (IF SOMEONE OTHER THAN YOURSELF)

FIRST NAME _____ LAST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____ PHONE NUMBER _____

RELATIONSHIP TO YOU _____

Insurance Information

PRIMARY INSURANCE _____ POLICY # _____ GROUP# _____

PRIMARY INSURANCE POLICY HOLDER (SELF OR OTHER) _____

(IF OTHER) NAME _____ RELATIONSHIP TO YOU _____ DOB _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE OR REFERRING PHYSICIAN, TO CONSULTANTS IF NEEDED AND AS NECESSARY TO PROCESS INSURANCE CLAIMS, INSURANCE APPLICATIONS, AND PRESCRIPTIONS. I ALSO AUTHORIZE PAYMENTS OF MEDICAL BENEFITS TO PALMS ACUPUNCTURE AND WELLNESS.

PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. I HAVE HAD A CHANCE TO READ OVER THE FINANCIAL RESPONSIBILITY FORM.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

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JUPITER FLORIDA

Medical History Form

Personal Information

TODAY'S DATE _____

FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

Past Medical History

PLEASE CHECK ALL THAT APPLY

- ◯ ANXIETY
- ◯ ARTHRITIS
- ◯ ARTERIAL FIBRILLATION
- ◯ BREAST CANCER
- ◯ COLON CANCER
- ◯ COPD
- ◯ CORONARY ARTERY DISEASE
- ◯ DEPRESSION
- ◯ DIABETES
- ◯ RENAL DISEASE
- ◯ GERD (INFLUX)
- ◯ HEARING LOSS
- ◯ HEPATITIS
- ◯ HIGH BLOOD PRESSURE
- ◯ HIV / AIDS
- ◯ HIGH CHOLESTEROL
- ◯ LEUKEMIA
- ◯ LUNG CANCER
- ◯ LYMPHOMA
- ◯ PROSTATE CANCER
- ◯ RADIATION TREATMENT
- ◯ SEIZURES
- ◯ STROKE
- ◯ HYPOTHYROID
- ◯ HYPERTHYROID

◯ OTHER _____

Medications

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Social History

PLEASE CHECK ALL THAT APPLY

CIGARETTE SMOKING
- ◯ DAILY
- ◯ SOME DAYS
- ◯ FORMER SMOKER
- ◯ NEVER SMOKED

OPTIONAL
- ◯ NOT SEXUALLY ACTIVE
- ◯ SEXUALLY ACTIVE
  - ◯ 1 PARTNER
  - ◯ MORE THAN 1 PARTNER
  - ◯ SAME SEX PARTNER

- ◯ DRUG USE
- ◯ IV DRUG USE

ALCOHOL USE
- ◯ NONE
- ◯ 1 DRINK PER DAY
- ◯ 2 DRINKS PER DAY
- ◯ 3 OR MORE DRINKS PER DAY

Pharmacy Information

PHARMACY NAME _____ LOCATION _____ PHONE _____