#_____ Age ____

KADIVAR FAMILY MEDICINE NEW PATIENT INFORMATION FORM

Please provide the following information and answer the questions below. Information you provide here is protected as confidential and is used in determining acceptance/denial as a patient. A copy of your insurance cards and driver's license is required.

Today's Date: _____

NAME: LAST_____ FIRST _____ MI _____

ADDRESS: _____

CITY _____ STATE_____ ZIP_____

HOME PHONE: (_____) _____ Cell phone: (_____) _____

EMAIL: _____ Contact Preference: _____ Home _____Cell _____ Work

SEX: M ____ F ____ DOB: _____ SSN: _____

HEIGHT: _____ FT _____ IN WEIGHT _____ LBS

Marital Status: Single _____ Married _____ Domestic Partnership _____

Divorced _____ Widowed _____

SPOUSE/GUARDIAN NAME: _____

PHONE: (_____) _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____

PHONE: (_____) _____

PRIMARY INSURANCE _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

POLICY/ID NUMBER: _____ GROUP NUMBER: _____

SECONDARY INSURANCE _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

POLICY/ID NUMBER: _____ GROUP NUMBER: _____

***If no secondary insurance check here _____**

EMPLOYER: _____

EMPLOYER PHONE: (_____) _____

OCCUPATION: _____

Please do not write in this area:

Approved: _____ YES _____ NO Dr. Kadivar _____

Verified: _____ YES _____ NO Insurance Verification _____ Date: _____

REFERRED BY (IF ANY): _____

IS THE REFERRAL SOURCE A PATIENT HERE? Yes _____ No _____

CURRENT MEDICATIONS (name and dosage): _____

_____

_____

_____

SURGERIES (type and date): _____

_____

_____

HOSPITALIZATIONS (type and date): _____

_____

_____

Please list any first degree relatives who have experienced the following:

Heart Attack/Age of occurrence: _____

Stroke/Age of occurrence: _____

Diabetes: _____

High Blood Pressure: _____

Cancer: _____

Sudden Death/Age: _____

Other: _____

_____

Previous Physician: _____ **Phone:** _____

Reason for Changing Physicians: _____

The Reason for Your Visit: _____

_____

How would you rate your current health? Poor _____ Good _____ Excellent _____

Please list any sleep disorders you are currently experiencing: _____

_____

Do you regularly drink alcohol? Yes ____ No _____ If yes, what amount? _____

Do you drink > 4 cups of caffeinated beverages per day? Yes _____ No _____

Do you smoke? Yes _____ No _____ If yes, how many packs per day? _____ How long have you smoked? _____ years

Are you a former smoker? Yes ____ No ____ if yes, how many packs per day did you smoke? _____

How many years did you smoke? _____ years

Have you ever used street drugs? Yes _____ No _____ If yes, what type? _____

Are you currently using street drugs? Yes _____ No _____ If yes, what type? _____

Have you ever had or suffered from any of the following:

Allergies	**yes _____**	**no _____**
Asthma	**yes _____**	**no _____**
AIDS/HIV	**yes _____**	**no _____**
High Blood Pressure	**yes _____**	**no _____**
Thyroid Problems	**yes _____**	**no _____**
Respiratory Problems	**yes _____**	**no _____**
Migraines	**yes _____**	**no _____**
Chronic Cough	**yes _____**	**no _____**
Dizziness	**yes _____**	**no _____**
Low Blood Sugar	**yes _____**	**no _____**
Cancer (type: _____)	**yes _____**	**no _____**
Sinus Trouble	**yes _____**	**no _____**
Fainting spells	**yes _____**	**no _____**
Diabetes	**yes _____**	**no _____**
Hepatitis/Liver Problems	**yes _____**	**no _____**
Stomach Problems	**yes _____**	**no _____**
Tuberculosis	**yes _____**	**no _____**
Sexually Transmitted Disease	**yes _____**	**no _____**
Mental Health Problems	**yes _____**	**no _____**
Congestive Heart Failure	**yes _____**	**no _____**
High Cholesterol	**yes _____**	**no _____**
Stroke/Heat Exhaustion	**yes _____**	**no _____**
COPD	**yes _____**	**no _____**
Drug Addiction	**yes _____**	**no _____**

Do you have any allergies to:

Anesthesia	**yes _____**	**no _____**
Sulfa Drugs	**yes _____**	**no _____**
Narcotics	**yes _____**	**no _____**
Penicillin/Antibiotics	**yes _____**	**no _____**

Please describe other allergies: _____

_____