



p: 336.584.7728
f: 336.584.8730
e: info@drtracyedwards.com

PATIENT INFORMATION (Confidential)

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ E-Mail: _____
Driver's License # _____ Soc. Sec. # _____ Birthdate _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Employer's Name _____ Work Phone _____
Work Address _____ City _____ State _____ Zip _____
If Student, Name of School _____ Full Time Part Time

SPOUSE INFORMATION

Name _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ E-Mail: _____
Driver's License # _____ Soc. Sec. # _____ Birthdate _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Employer's Name _____ Work Phone _____
Work Address _____ City _____ State _____ Zip _____
If Student, Name of School _____ Full Time Part Time

PARENT INFORMATION (If A Student)

Name _____
Address _____ City _____ State _____ Zip _____
Home Phone # _____ E-Mail: _____
Driver's License # _____ Soc. Sec. # _____ Birthdate _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
Employer's Name _____ Work Phone _____
Work Address _____ City _____ State _____ Zip _____
If Student, Name of School _____ Full Time Part Time

Person to contact in case of an emergency _____ Phone # _____
Whom may we thank for referring you? _____
Do you have dental insurance? Yes No If so, please present insurance card.

Over Please ↩

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|--------|--------------------------|--------------------------|---------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|--------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____
_____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, what medication(s) are you taking? _____
_____</p> <p>4. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you have or have you had any of the following?</p> | <p>8. Are you allergic to or have you had any reactions to the following:</p> <table border="0" style="width: 100%;"> <tr><td>Local Anesthetics (eg. novocaine)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Penicillin or any other Antibiotics</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Sulfa Drugs</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Barbiturates</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Sedatives</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Iodine</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Aspirin</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Any Metals (eg. nickel, mercury etc.)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Latex Rubber</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Other _____</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </table> <p>9. Women Only:</p> <p>A) Are you pregnant or think you may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B) Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C) Are you taking oral contraceptives? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (eg. nickel, mercury etc.) | <input type="checkbox"/> | <input type="checkbox"/> | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Local Anesthetics (eg. novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Iodine | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Aspirin | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any Metals (eg. nickel, mercury etc.) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

CANCELLATION POLICY

At least 24 hours notice is required to cancel an appointment that is scheduled for less than one hour. If my scheduled appointment is for more than one hour, I understand that 48 hours notice is necessary to cancel. If this policy is not adhered to, I understand there may be a charge based on the amount of time reserved for me.

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such health care to third party payors and/or health practitioners.

LATE CHARGES

Payment in full is required at each appointment. If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent if minor)

Doctor's Comments _____

Signature _____ Date _____