

Prefix \_\_\_\_\_ Last name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Suffix \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender \_\_\_\_\_ Marital status \_\_\_\_\_ Previous doctor and where you heard about us \_\_\_\_\_  
 Nickname \_\_\_\_\_ Home Address \_\_\_\_\_ Home City \_\_\_\_\_ State \_\_\_\_\_ Home Zip \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ Email address \_\_\_\_\_ Degree & education level \_\_\_\_\_  
 Work name \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Pharmacy Name and city \_\_\_\_\_

Primary Insurance \_\_\_\_\_ Primary Insurance Policy Number OR ID# \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ Secondary Insurance Policy Number OR ID# \_\_\_\_\_ Group # \_\_\_\_\_ Insurance Phone Number \_\_\_\_\_

Reason for visit today \_\_\_\_\_  
 Main symptoms \_\_\_\_\_  
 Current medications including herbals and over the counter \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

MEDICATION ALLERGIES \_\_\_\_\_

Surgeries & Hospitalizations

<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Other illnesses (list)
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Mitral Regurgitation	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Autoimmune illness	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> Seizures	
<input type="checkbox"/> Cancer (including treated)	<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Sickle Cell Anemia	
<input type="checkbox"/> Chest pain or angina	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Spleen Removed	
<input type="checkbox"/> Cough	<input type="checkbox"/> Hernia	<input type="checkbox"/> Stroke or TIA	
<input type="checkbox"/> Depression	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid illness	

tobacco (type, amount/day, years used) \_\_\_\_\_  
 alcohol (type, amount/day, years used) \_\_\_\_\_ drug use, including marijuana \_\_\_\_\_  
 up to date Immunizations  yes  no I wear seatbelts, have smoke detectors, and have a safe home  yes  no  
 Family illnesses Mom \_\_\_\_\_ Dad \_\_\_\_\_  
 Sisters \_\_\_\_\_ Grandparents \_\_\_\_\_  
 Brothers \_\_\_\_\_  
 Emergency contact person \_\_\_\_\_  
 Emergency contact phone number \_\_\_\_\_ emergency contact relationship \_\_\_\_\_

I consent to have The Country Doctor treat myself, or the person named on this form, if I am that person's legal guardian.  
 I consent to have my insurance, HMO, PPO, Medicare, etc., billed for my care by The Country Doctor, Ltd, and  
 I consent to release medical information to process claims concerning the person listed on this form. Please note that  
 insurances require patients to pay a copay, a percentage of the visit, and/or a deductible. Some tests and procedures may  
 not be covered by insurances, including Medicare, and you are responsible for these fees and deductibles. I understand  
 that it is my responsibility to check with my health coverage plan regarding the coverage of any tests and immunizations.  
 I have reviewed the payment policies, and I will pay the required fees. Please review page 2, the privacy policies. ---->

Signature of patient, parent, or guardian \_\_\_\_\_ Date \_\_\_\_\_ Printed name of person who signs the form and relationship to patient \_\_\_\_\_