PATIENT INFORMATION

Last Name: _____ First Name: _____MI: _____

Date of Birth: _____Social Security: _____

Height: _____ ft. _____in. Weight: _____lbs. Sex: M F Marital Status: S M D W

Preferred Language: _____

Office use only: BP _____

Race (circle one): American Indian Alaska Native Asian White Native Hawaiian Other Pacific Islander Black or African American Declined to State

Ethnicity (circle one): Declined to State Hispanic or Latino Not Hispanic or Latino

Smoking Status (circle one): Current Every Day Smoker Current Some Day Smoker Former Smoker Never Smoker

In an effort to quit smoking, I am currently_____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Are you currently taking any medication? Yes No if yes, please indicate:

Med/Dosage_____ Med/Dosage_____ Med/Dosage_____

Med/Dosage_____ Med/Dosage_____ Med/Dosage_____

Do you have allergies to medication? Yes No, if yes, please indicate:

Allergen/Reaction_____ Allergen/Reaction_____

Allergen/Reaction_____ Allergen/Reaction_____

Nearest Relative: _____ Phone: _____

In Case Of Emergency Notify (Name & Phone Number): _____

Patient's Signature: _____ Date: _____

Guardian/Parent if patient is a minor: _____ Date: _____