



## Welcome To Our Office

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First Middle Last

Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
E-Mail: \_\_\_\_\_

*Complete this section only if someone other than the patient is financially responsible (eg if patient is a minor or patient has a legal power of attorney for financial matters).*

Responsible Party: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer's Telephone: ( ) \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

How did you learn about our facility? \_\_\_\_\_  
Can we mail information to your home? Yes No  
Can we leave a message for you at home? Yes No  
Can we leave a message for you at work? Yes No  
Can we send e-mail to you at the address provided? Yes No

## Insurance Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
          First                    Middle                    Last

*[Primary Insurance]*

Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Insured's DOB: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

*[Secondary Insurance]*

Name of Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Insured's DOB: \_\_\_\_\_ Insured's SSN: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

Did your injury happen on the job?                    Yes    No  
If yes, on what date did the injury occur?                    \_\_\_\_\_  
Did you report the accident to your employer?                    Yes    No

Our office will file insurance for all reimbursement services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's visit:    \_\_\_Cash    \_\_\_Check    \_\_\_Visa/MC    \_\_\_AMEX

Signature of Patient or Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

<p>I authorize the release of any medical information necessary to process my claim.</p> <p>Signed: _____           (Patient or responsible party)</p> <p>Date: _____</p>
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<p>I authorize payment of medical and surgical benefits to Gregory H. Pastrick, MD.</p> <p>Signed: _____           (Patient or responsible party)</p> <p>Date: _____</p>
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# HEALTH HISTORY

## (CONFIDENTIAL)

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 AGE: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_  
 WHAT IS YOUR REASON FOR VISIT? \_\_\_\_\_

SYMPTOMS (You currently have or have had in past year, check )

- |  |  |  |  |
|--|--|--|--|
| <p><b>GENERAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chills</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Fever</li> <li><input type="checkbox"/> Forgetfulness</li> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Loss of Sleep</li> <li><input type="checkbox"/> Loss of Weight</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Sweats</li> </ul> <p><b>MUSCLE/JOINT/BACK</b><br/>Pain, weakness, numbness in:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arms    <input type="checkbox"/> Hips</li> <li><input type="checkbox"/> Back    <input type="checkbox"/> Legs</li> <li><input type="checkbox"/> Feet    <input type="checkbox"/> Neck</li> <li><input type="checkbox"/> Hands    <input type="checkbox"/> Shoulders</li> </ul> <p><b>GENITOURINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Lack of bladder control</li> <li><input type="checkbox"/> Painful urination</li> </ul> | <p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Appetite poor</li> <li><input type="checkbox"/> Bloating</li> <li><input type="checkbox"/> Bowel changes</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Excessive hunger</li> <li><input type="checkbox"/> Excessive thirst</li> <li><input type="checkbox"/> Gas</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Indigestion</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Rectal Bleeding</li> <li><input type="checkbox"/> Stomach Pain</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Vomiting blood</li> </ul> <p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Varicose veins</li> <li><input type="checkbox"/> Chest pains</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Irregular heartbeat</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Poor circulation</li> <li><input type="checkbox"/> Rapid heartbeat</li> <li><input type="checkbox"/> Swelling of ankles</li> </ul> | <p><b>EYE,EAR,NOSE,THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bleeding gums</li> <li><input type="checkbox"/> Blurred vision</li> <li><input type="checkbox"/> Crossed eyes</li> <li><input type="checkbox"/> Difficulty swallowing</li> <li><input type="checkbox"/> Double vision</li> <li><input type="checkbox"/> Earache</li> <li><input type="checkbox"/> Ear discharge</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Nosebleeds</li> <li><input type="checkbox"/> Persistent cough</li> <li><input type="checkbox"/> Ringing in ears</li> <li><input type="checkbox"/> Sinus problems</li> <li><input type="checkbox"/> Vision - flashes</li> <li><input type="checkbox"/> Vision - halos</li> </ul> <p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sore that won't heal</li> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Hives</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Change in moles</li> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> Scars</li> </ul> | <p><b>MEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Erection difficulty</li> <li><input type="checkbox"/> Lump in testicle</li> <li><input type="checkbox"/> Penis discharge</li> <li><input type="checkbox"/> Sore on penis</li> <li><input type="checkbox"/> Other</li> </ul> <p><b>WOMEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Abnormal pap</li> <li><input type="checkbox"/> Bleeding between periods</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Extreme menstrual bleeding</li> <li><input type="checkbox"/> Hot flashes</li> <li><input type="checkbox"/> Nipple discharge</li> <li><input type="checkbox"/> Painful intercourse</li> <li><input type="checkbox"/> Vaginal Discharge</li> <li><input type="checkbox"/> Other</li> </ul> <p>Date last menstrual period: _____</p> <p>Date last Pap smear: _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children: _____</p> |
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CONDITIONS (you have or have had in the past, check )

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|---|---|---|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> AIDS</li> <li><input type="checkbox"/> Alcoholism</li> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Anorexia</li> <li><input type="checkbox"/> Appendicitis</li> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Bleeding disorders</li> <li><input type="checkbox"/> Breast lump</li> <li><input type="checkbox"/> Bronchitis</li> <li><input type="checkbox"/> Bulimia</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Cataracts</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Chemical dependency</li> <li><input type="checkbox"/> Chicken pox</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Emphysema</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Goiter</li> <li><input type="checkbox"/> Gonorrhea</li> <li><input type="checkbox"/> Gout</li> <li><input type="checkbox"/> Heart disease</li> <li><input type="checkbox"/> Hepatitis</li> <li><input type="checkbox"/> Hernia</li> <li><input type="checkbox"/> Herpes</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> High cholesterol</li> <li><input type="checkbox"/> HIV positive</li> <li><input type="checkbox"/> Kidney disease</li> <li><input type="checkbox"/> Liver disease</li> <li><input type="checkbox"/> Measles</li> <li><input type="checkbox"/> Migraine headaches</li> <li><input type="checkbox"/> Miscarriage</li> <li><input type="checkbox"/> Mononucleosis</li> <li><input type="checkbox"/> Multiple Sclerosis</li> <li><input type="checkbox"/> Mumps</li> <li><input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Polio</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Prostate problems</li> <li><input type="checkbox"/> Psychiatric problems</li> <li><input type="checkbox"/> Rheumatic fever</li> <li><input type="checkbox"/> Scarlet fever</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Suicide attempt</li> <li><input type="checkbox"/> Thyroid problems</li> <li><input type="checkbox"/> Tonsillitis</li> <li><input type="checkbox"/> Tuberculosis</li> <li><input type="checkbox"/> Typhoid fever</li> <li><input type="checkbox"/> Ulcers</li> <li><input type="checkbox"/> Vaginal Infections</li> <li><input type="checkbox"/> Venereal Disease</li> </ul> |
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MEDICATIONS currently taking:

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ALLERGIES:

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