PATIENT CONFIDENTIAL INFORMATION RECORD

WELCOME TO THE OFFICE OF DAVID M. TRASK M.D., LLC

ACCT TYPE: _____ **ACCT #**_____

Please mark an (X) to indicate the best phone number to contact you during our normal business hours.

( ) Home Phone: (_____) _____
( ) Work Phone: (_____) _____EXT_____
( ) Cell Phone: (_____) _____

Who referred you to our office: _____

Who is your Primary Care Physician / Provider: _____

PATIENT LEGAL NAME: _____
First MI Last

Nickname: _____ **Date of Birth:** _____ **AGE:** _____

Sex: Male / Female **Marital Status:** *(CIRCLE ONE)* Single / Married / Divorced / Widowed

Social Security #_____ **Driver's License#** _____

Address: _____
Street City State Zip

Mailing Address: _____

EMPLOYMENT/SELF-EMPLOYED INFORMATION: Occupation/Position: _____
Employer Name: _____Work Phone: _____Ext:_____
May we call you at work? ___YES ___NO Work Shift: _____

SPOUSE / PARTNER / LEGAL GUARDIAN: *(CIRCLE ONE)*
Name: _____Phone # (_____) _____
Address: _____
Date of Birth: _____ Social Security #: _____ Driver's License #: _____
Employer: _____ Phone #: _____Ext_____

EMERGENGY CONTACT INFORMATION: ***Friend or Relative not living with you.***
Name: _____Relationship:_____
Address: _____
Home Phone # (_____) _____ Cell/Work Phone#: (____) _____

MAY WE SPEAK WITH ANYONE ELSE IN REGARDS TO YOUR MEDICAL CARE:

_____
Name **Relationship** **(Area Code) Phone Number**

I HEREBY GIVE MY PERMISSION TO LEAVE A VOICE MAIL MESSAGE ON MY PHONE REGARDING MY TREATMENT, LAB OR PATHOLOGY RESULTS. I ALSO GIVE MY PERMISSION TO TRANSMIT VIA FACSIMILE, MY PERSONAL MEDICAL RECORDS THAT MAY BE NECESSARY TO MY TREATING MEDICAL PROVIDER(S).

_____ _____ _____
Signature **Self / Other** **Date**

CONFIDENTIAL HEALTH QUESTIONNAIRE

PATIENT NAME: _____ **DATE OF BIRTH:** _____

AGE: _____

REASON FOR YOUR VISIT TODAY: _____

Are you Pregnant or Nursing? __Yes __No **If yes, how many months?** _____

Are you ALLERGIC to Local Anesthetics? Yes_____ No_____ Type _____
Are you ALLERGIC to? Latex _____ Band-Aids _____ Tape _____ Other_____
Any other known ALLERGIES: _____

Do you take Aspirin? Yes No **Do you take Blood Thinners? Yes No**

Please list all Medications / Vitamins / Herbs you are currently taking: None: _____

Name	*Size / Dose*	*Frequency Taken*

Personal Medical History: *Please ✓ if you have or ever had any of the following:*

__Skin Cancer	__Melanoma	__Squamous Cell	__Basal Cell
__Eczema	__Asthma	__Hay Fever	__Psoriasis
__Seborrhea	__Depression	__Anxiety	__Dementia/Alzheimer's
__Herpes	__Hepatitis A-B-C	__HIV/Aids	__Venereal Disease
__ High/Low Blood Pressure	__Heart Valve/Stent	__Pacemaker	__Heart Disease
__Gallbladder Disease	__Lung Disease	__Kidney Disease	__Thyroid Disease
__Dizziness/Fainting	__Circulatory Problems		Hyper/Hypo
__Difficulty Breathing	__Tuberculosis	__Fibromyalgia	
__Arthritis	__Gout	__Shingles	__Sinus Problems
__High Cholesterol	__Excessive Bleeding	__Anemia	__Diabetes
__Ear Problems	__Hearing Aid(s) – Left / Right / Both		__Eye Problems
__Multiple Sclerosis	__Cerebral Palsy	__Epilepsy	__Rheumatic Fever
__Immune Suppressed	__Lupus	__Other_____	

__Cancer: _____ Radiation/Chemo Therapy: _____
__Organ Transplant (type) _____ Artificial Joint: _____

Major Surgeries:

_____
_____
_____

I, the undersigned, certify that the above statements are true to the best of my knowledge.

_____ _____ _____
Signature Self / Guardian Date

– Over –