

DAVID C. REDD, M.D., P.C.

PLEASE PRINT

DATE ____ / ____ / ____

PATIENTS FULL NAME _____ DOB _____ AGE _____

HOME PHONE _____ CELL PHONE _____ SS# _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____ MALE _____ FEMALE _____

EMPLOYER _____ WORK PHONE _____

EMPLOYER ADDRESS _____

CITY _____ STATE _____ ZIP _____

PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____

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SPOUSE/PARENT/GUARDIAN _____ RELATIONSHIP _____

ADDRESS _____

SS# _____ DOB _____ WORK PHONE _____

EMPLOYER _____

EMPLOYER ADDRESS _____

EMERGENCY CONTACT AND RELATIONSHIP _____ PHONE _____

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PRIMARY INSURANCE _____ INSURED'S NAME _____

DOB _____ GROUP # _____ ID# _____

INSURED'S RELATIONSHIP TO PATIENT _____ EMPLOYER _____

SECONDARY INSURANCE _____ INSURED'S NAME _____

DOB _____ GROUP# _____ ID# _____

INSURED'S RELATIONSHIP TO PATIENT _____ EMPLOYER _____

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ASSIGNMENT AND RELEASE

I authorize the payment of medical benefits to David C. Redd, M.D., P.C. for services rendered to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. This office also has my permission to release my medical records to another medical facility if the occasion should arise.

SIGNATURE _____ DATE _____

MEDICARE ASSIGNMENT AND RELEASE

I request that payment of authorized Medicare benefits be made on my behalf to David C. Redd, M.D., P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE _____ DATE _____

DAVID C. REDD, M.D., P.C.

Name _____ Date _____ Occupation _____

Name of Medicine Dose Prescribed By

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medication Allergies? _____

Past Surgical/Procedures Date Surgeon's Name

1. _____
2. _____
3. _____
4. _____
5. _____

Do you use alcohol? _____ How often? _____ Drugs? _____

Do you smoke or use any type of tobacco? _____ Number of packs/day _____

Does anyone in your family (or you) have a bleeding or clotting disorder? _____

Has anyone in your family (or you) had a problem with general anesthesia? _____

Family Medical History Yes No If yes, relation to patient

Cancer _____

Diabetes _____

Heart Disease _____

Stroke _____

PAST MEDICAL HISTORY (Personal) (Check ALL previous illnesses or conditions below.)

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Circulation | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Kidney/Urine | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> BP | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Bleeding | _____ |
| <input type="checkbox"/> Freq. Infections | <input type="checkbox"/> Diabetes | _____ |

DAVID C. REDD, M.D., P.C.

NAME: _____

DATE: _____

REVIEW OF SYSTEMS

General:

- NONE OTHER
- fever-chills
- sweats
- change in sleep habits
- fatigue
- weight gain
- weight loss
- pain-location _____ level(0-10)

GASTROINTESTINAL

- NONE OTHER
- yellow skin or eyes
- cramping/stomach gain
- nausea/vomiting
- indigestion
- change in appetite/diet
- reflux
- bloody or black stools
- constipation diarrhea

NEUROLOGICAL:

- NONE OTHER
- dizziness/fainting
- weakness
- headache
- hearing difficulty
- seizures
- speech changes

GENITOURINARY

- NONE OTHER
- burning
- frequency
- blood in urine
- dribbling
- unable to control bladder

HEAD & NECK

- NONE OTHER
- nose bleeds
- sore throat

RESPIRATORY

- NONE OTHER
- wheezing cough
- short of breath

CARDIOVASCULAR

- NONE OTHER
- pacemaker/automatic defibrillator
- leg pain/swelling
- chest pain
- fast heart beat

Hematology

- NONE OTHER
- abnormal bleeding
- prior transfusion
- easy bruising

MUSCULOSKELETAL

- NONE OTHER
- joint swelling/stiffness
- joint/back pain

SKIN

- NONE OTHER
- open sore rashes
- change in moles

MEDICATIONS

- Plavix**
- Steroids (prednisone, etc.)**
- Birth control Pills**

- Insulin**
- Aspirin**
- Coumadin**