

MEDICAL INFORMATION FORM

Patient Name: _____ Date of Birth: _____

Contact Information:

Address: _____

Phone Number: _____

Email: _____

Emergency Contact:

Name: _____

Relationship: _____

Phone Number: _____

Insurance Information:

Insurance Provider: _____

Policy Number: _____

Group Number: _____

Medical History:

Allergies (medications, food, environmental): _____

Current Medications: _____

Past Surgeries or Hospitalizations: _____

Chronic Conditions (e.g., diabetes, hypertension): _____

Family Medical History (significant diseases): _____

Primary Care Physician Name and Contact: _____

Lifestyle and Habits:

Do you smoke? (Yes / No): _____

Do you consume alcohol? (Yes / No): _____

Do you use recreational drugs? (Yes / No): _____

Exercise frequency and type: _____

Dietary considerations or restrictions: _____

Consent and Legal Acknowledgments:

I hereby certify that the above information is true and accurate to the best of my knowledge. I understand that withholding information or providing false information may endanger myself or others. I consent to the use and disclosure of my medical information for treatment, payment, and healthcare operations in accordance with applicable

United States laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA). I acknowledge that I have been provided with a privacy notice explaining how my information will be used and protected.

Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Patient's Signature

Healthcare Provider's Signature

Signature: _____

Signature: _____

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