PATIENT INFORMATION

PLEASE PRINT CLEARLY AND COMPLETE FORM ENTIRELY

NAME: ____ **DATE OF BIRTH:** ____________
(Last) (First) (Middle) (MM/DD/YYYY)

ADDRESS: ____
(Street) (City) (State) (Zip)

SEX: **M** **F** **MARITAL STATUS:** **S** **M** **D** **W**

HOME PHONE: ____________________ **SS:** ____________________

CELL PHONE: ____________________ **E-MAIL ADDRESS** ____________________

MAY WE USE YOUR E-MAIL TO COMMUNICATE WITH YOU REGARDING YOUR HEALTHCARE? ____________________

WORK PHONE: ____________________ **OCCUPATION:** ____________________

EMPLOYER: ____________________ **CITY:** ____________________ **STATE:** __________

SPOUSE'S NAME: ____________________

MOTHER'S MAIDEN NAME: ____________________

WHO MAY WE CONTACT IN AN EMERGENCY? ____________________

May we leave messages regarding your health and medical conditon with this person? ____________________

THEIR PHONE NUMBER: ____________________ **RELATIONSHIP TO PATIENT:** ____________________

MEDICARE#: ____________________ **TENNCARE#:** ____________________

OTHER INSURANCE OR TYPE OF TENNCARE: ____________________

WHO REFERRED YOU TO THIS OFFICE? ____________________

ALLERGIES? ____________________

WHAT MEDICAL PROBLEMS DO YOU HAVE? ____________________

WHAT SURGERIES HAVE YOU HAD? ____________________

ARE THERE ANY MEDICAL PROBLEMS THAT RUN IN YOUR FAMILY? (If yes, what?**)** ____________________

DO YOU SMOKE OR USE ANY OTHER TYPE OF TOBACCO? (If yes, what and how much?) ____________________

DO YOU DRINK ALCOHOL AT ALL?(If yes, what and how much?) ____________________

DO YOU USE DRUGS OF ANY KIND? (If yes, what and how much?) ____________________

RESPONSIBLE PARTY NAME: ____________________

RELATIONSHIP TO PATIENT: ____________________

ADDRESS: ____________________ **DATE OF BIRTH:** ____________________

PHONE: ____________________ **SS#:** ____________________

EMPLOYER: ____________________ **WORK PHONE:** ____________________

Drs Rentrop and Geater PLLC have given me a copy of the Notice of Privacy Practices for Protected Health Information.

Signed: X ____ **Date:** ____________