PATIENT'S INFORMATION

Last Name First Name Middle Name	Sex ☐ M ☐ F	Age	Birthdate ____/____/______
Patient's Address			
City State Zip code			

Home Phone ( )	Mobile Phone ( )	Social Security Number
Marital Status (Please Circle One) Single Married Divorced Separated Widowed		Email Address
Occupation		Language Spoken
Employer's Name		Office Phone ( )

Primary Care Physician	Office Phone ( )
Referring Physician	Office Phone ( )

PERSONAL INSURANCE INFORMATION - PRIMARY

Subscriber's Name	Patient's Relationship to Subscriber
Insurance	ID Number

PERSONAL INSURANCE INFORMATION - SECONDARY

Subscriber's Name	Patient's Relationship to Subscriber
Insurance	ID Number

NAME OF RELATIVE OR FRIEND – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)

Name/Relationship	Phone ( )

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Danny Benmoshe, M.D., Inc. to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits.

Patient's Signature	Date

COMPREHENSIVE PATIENT HISTORY

Patient's Name:	Date:

What is the main reason for your visit today? (Please Describe)

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____

ALLERGIES TO FOOD/MEDICATION (INCLUDING TYPE OF REACTION)

1. ____________________ 3. ____________________
2. ____________________ 4. ____________________

MEDICAL HISTORY (Please indicate if you have or have had any of the following by encircling Yes or No, followed by a brief explanation, including dates.)

Condition			Explanation
High Blood Pressure	YES	NO	________
High Cholesterol	YES	NO	________
Diabetes	YES	NO	________
Cardiac Disease	YES	NO	________
Strokes	YES	NO	________
Seizure Disorders	YES	NO	________
Migraines	YES	NO	________
Thyroid Disease	YES	NO	________
Lung Disease (Type)	YES	NO	________
Liver Disease/Hepatitis	YES	NO	________
Kidney Disease	YES	NO	________
Cancer	YES	NO	________
Bleeding Disorder/Tendency	YES	NO	________
Gastrointestinal Disorder	YES	NO	________
Depression/Anxiety	YES	NO	________
Other Conditions (Specify)	YES	NO	________

(Women) Number of Pregnancies: _______ Vaginal Deliveries: _______ C-sections: _______

SURGICAL HISTORY (please list all operations that you have had and when they were done.)

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FAMILY HISTORY (Please list any family history of high blood pressure, high cholesterol, diabetes, strokes, seizures, migraines or any other diseases)

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____

LABORATORY OR DIAGNOSTIC IMAGING (Please list any recent laboratory or related imaging done in the last 3 years)

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MEDICATIONS (Please fill in attached sheet)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY USING

This list should include prescription medications, over the counter medications (Tylenol, Aspirin, Advil, etc.) and any vitamins or herbs. Try to be specific as possible about the amount and frequency of use of these medications.

Medication Name	Dose (mg or # of pills)	Doses per Day	Days per Week

PLEASE LIST ALL PREVIOUS MEDICATIONS YOU'VE TAKEN IN THE PAST

This is a list of all medications that you have taken in the past for your symptoms including prescription medications, over the counter medications. Please indicate why you are no longer taking this medication.

Medication Name	Reason for Discontinuing