

Ronald S. Bergman, D.O., P.C.

Patient Information Sheet

Patient:

•• (All fields must be completed to file insurance)

Legal Name _____

First Middle Last

Male _____ Female _____ Age _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone# (____) _____ Cell Phone (____) _____

Social Security Number: _____ (Needed to file your insurance)

Student _____ Yes _____ No _____ Full time _____ Part time _____

Marital Status: Please circle Married Single Divorced Widow/Widower

Employer's Name _____

Employer's Address (Complete) _____

Employer's Phone (____) _____

Spouse:

Legal Name _____

First Middle Last

Date of Birth _____

Social Security Number: _____

Employer's Name _____

Employer's Address (Complete) _____

Employer's Phone (____) _____

Person Responsible for payment (if other than patient):

Legal Name _____

First Middle Last

Relationship to patient _____

Social Security Number: _____

Date of Birth: _____

Address _____ Home Phone(____) _____

Employer's Name _____

Employer's Address (Complete) _____

Employer's Phone (____) _____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance. I understand that I will be charged a monthly late payment fee for all patient balances not paid in full.

Insurance Coverage

A COPY OF THE INSURANCE CARD MUST BE PRESENTED AT TIME OF VISIT

• *(Need all lines completed in order to file insurance)*

Primary Insurance:

Insurance Name _____
Person Carrying Ins. _____
Date of Birth _____
Relationship to patient _____
ID#: _____
Group#: _____
Effective Date: _____
Employer insured through: _____

Secondary Insurance:

Insurance Name _____
Person Carrying Ins. _____
Date of Birth _____
Relationship to patient _____
ID#: _____
Group#: _____
Effective Date: _____
Employer insured through: _____

In case of an emergency, name of person NOT living with patient we can contact:

Name _____ Phone# _____

Relationship to patient: _____

Patient Signature and/or Parent or Guardian: X _____

Today's Date: _____

Patient Medical History

Name: _____ Date: _____

How were you referred to us today?

- By another physician (name): _____
 Phone Book Newspaper Radio TV Friend Other _____

Allergies: _____

Are you allergic or sensitive to latex, balloons, rubber, etc.? Yes No Last tetanus? _____

Family physician: _____

Why are we seeing you today? _____

Were you seen in the emergency room? Yes No – When? _____

Were X-rays or any other tests taken for this injury? Yes No

If yes, explain: _____

Do you take medications for any reason (prescription and/or over-the-counter)? Yes No

If so, please list them: _____

Do you smoke or have you ever had a history of smoking? Yes No

Amount per day? _____ For how long? _____

Do you drink alcohol? Yes No – Amount per day? _____ For how long? _____

Do you or have you ever used narcotics? Yes No – if yes, please explain: _____

Have you ever had any of the conditions listed below? If yes, please give details.

- Anemia Yes No _____
- Asthma/Hayfever/Allergies Yes No _____
- Blurred/Double Vision Yes No _____
- Cardiac Problems Yes No _____
- Chest Pain Yes No _____
- Chronic Cough Yes No _____
- Colitis/Bowel Disease Yes No _____
- Diabetes Yes No _____
- Ear/Nose/Throat Problems Yes No _____
- Gallbladder Disease Yes No _____
- Heart Murmur Yes No _____
- Hepatitis/Yellow Jaundice .. Yes No _____
- HIV/AIDS Yes No _____
- Hypertension Yes No _____
- Kidney Disorder Yes No _____
- Pneumonia Yes No _____
- Polio/Meningitis Yes No _____
- Psychiatric Disorder Yes No _____
- Rheumatic Fever Yes No _____
- Seizure Disorder Yes No _____
- Tuberculosis Yes No _____
- Unconscious/Fainting Spells Yes No _____

(over)

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Have you ever been pregnant? Yes No

If yes, number of: vaginal deliveries _____ c-sections _____ miscarriages _____ abortions _____

Have you ever had surgery before? Yes No

If yes, please list names of all surgeries: _____

Have you ever had a general anesthetic? Yes No

If yes, any adverse reactions? _____

Have you ever had a blood transfusion? Yes No – If yes, date: _____

FAMILY HISTORY:

Cancer Yes No _____

Diabetes Yes No _____

Epilepsy Yes No _____

Heart Disease Yes No _____

High Blood Pressure Yes No _____

Is there any other significant history that we should be aware of? Yes No – If yes, explain: _____

To the best of my knowledge, the medical information supplied is accurate and complete.

Signature of Patient

or Parent/Guardian: _____ Date: _____

This section is to be completed by the physician or nurse.

B/P:

Height:

Weight:

HEENT:

Cardiovascular:

Respiratory:

Gastrointestinal:

Urogenital:

Extremities:

Neurological:

Physician's Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____

Receipt of Notice of Privacy Practices

Acknowledgment of Receipt of Notice of Privacy Practices

I would like to request the following restrictions on the uses and disclosures of my protected health information. Place a check mark on the applicable line.

I do not wish to be contacted about reminder appointments by phone.

I do not wish to be contacted about reminder appointments by mail.

I do not wish to be contacted about future open houses for seminars regarding cosmetic procedures and/or products.

If the above restricted information is needed to provide me with emergency treatment, or cancellation of an appointment due to an emergency on the part of Ronald S. Bergman, D.O., P.C., you may suspend the above agreement.

Name of Patient or Personal Representative(Printed)

Signature of Patient or Personal Representative

Date

My signature on this form indicates that I have received a Notice of Privacy Practices. If you have any questions, please contact our Privacy Officer at 515-222-1111.

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date