

## PATIENT INFORMATION

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MID INIT \_\_\_\_\_  
ADDRESS \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
CITY \_\_\_\_\_ SOC SEC NO. \_\_\_\_\_ SEX M  F   
STATE \_\_\_\_\_ ZIP \_\_\_\_\_ BIRTHPLACE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
WORK PHONE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

## PERSON TO CONTACT IN AN EMERGENCY (SPOUSE, NEIGHBOR, FRIEND OR RELATIVE):

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

## INSURANCE / PAYSOURCE

PRIMARY \_\_\_\_\_ SECONDARY \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_ POLICY HOLDER \_\_\_\_\_  
NUMBER \_\_\_\_\_ NUMBER \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ TELEPHONE \_\_\_\_\_

## MEDICAL INFORMATION

ALLERGIES \_\_\_\_\_ CIGARETTES: YES \_\_\_\_\_ NO \_\_\_\_\_  
FAMILY / PCP / DOCTOR(S) \_\_\_\_\_ HOW MUCH? \_\_\_\_\_  
LIST MEDICATIONS \_\_\_\_\_  
\_\_\_\_\_  
PREVIOUS SURGERY \_\_\_\_\_  
MEDICAL PROBLEMS \_\_\_\_\_  
I WAS REFERRED BY \_\_\_\_\_ DATE OF ONSET OR INJURY \_\_\_\_\_  
REASON FOR THIS VISIT \_\_\_\_\_

## SIGNATURE

By signing

I acknowledge that the above information is complete, true and correct  
I authorize the release of all medical information as needed to and from Doctor Cuadros  
I authorize the use of photography  
I acknowledge that I am entering into a physician-patient relationship with Doctor Cuadros  
I agree to comply with the care, medication, instructions and treatment prescribed to me by the doctor  
I agree to be responsible for all financial charges incurred as a result of my evaluation and treatment

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_