



**Surgery:** Yes \_\_\_ No \_\_\_

<u>Reason</u>	<u>Year</u>
_____	_____
_____	_____
_____	_____

Have you or a close family member ever had problems with anesthesia? Yes \_\_\_ No \_\_\_

If yes , please describe: \_\_\_\_\_

**Allergies:** Yes \_\_\_ No \_\_\_

List all drugs or substances to which you are allergic and specify the type of reaction: itching, rash, hives, wheezing, swelling, difficulty breathing, etc.

<u>Drug/Substance</u>	<u>Reaction</u>
_____	_____
_____	_____

**Medications:** Yes \_\_\_ No \_\_\_ If you have a list, please give it to receptionist!

List all medications which you now take regularly to include diet supplements/vitamins and herbal preparations.

<u>Medication</u>	<u>Strength</u>	<u>Times per day</u>	<u>Alcohol Use</u>	<u>Tobacco Use</u>
_____	_____	_____	___ 1-2 drinks/day	# of years _____
_____	_____	_____	___ 1-2 drinks/week	Packs/Day _____
_____	_____	_____	___ 3 or more/day	
_____	_____	_____	___ Rarely Drinks	
_____	_____	_____		

Remarks \_\_\_\_\_

**Release and Assignment:**

1. I authorize the release of any medical information necessary to process my insurance claims.
2. I authorize and request payment of medical benefits directly to my physicians.
3. I agree that this authorization will cover all medical services rendered until revoked by me.
4. I understand that I am responsible for **all insurance deductibles and amounts not otherwise covered by my insurance.**
5. **Payment is expected at time of service unless other arrangements are made.**

By typing your name below you are agreeing to the above conditions.

Typed by Patient or Guardian	Date
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Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

