Primary Care Physician: _____ Last Visit: _____

Practice: LOMBARDI AND SILVER, LLP **Chart Number:**

Name: _____ **Date of birth:** _____

Race: _____ ☐I prefer not to answer ☐I do not know
(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)

Ethnicity: _____ ☐I prefer not to answer ☐I do not know

Preferred Language: _____ ☐I prefer not to answer

Privacy Information Preferences

Were you offered a copy of the HIPAA Privacy Practice Notice? ☐Yes ☐No

Do you want to be exempt from public reporting? ☐Yes ☐No

Can we send mail to the address on file? ☐Yes ☐No

Can we call the phone number on file? ☐Yes ☐No

Can we leave voicemail on answering machine? ☐Yes ☐No

Will you allow internet based delivery reminders like email? ☐Yes ☐No

Who can we leave messages with? ☐ Wife ☐Husband ☐Daughter ☐Son

☐ Other: _____

***PHARMACY INFO*:**

Smoking Status

☐ Current Every Day Smoker

☐ Current Some Day Smoker

☐ Former Smoker

☐ Never Smoker

☐ I decline to answer

Vital Signs

Blood Pressure: _____ / _____

Height: _____

Weight: _____

☐I prefer not to answer ☐I do not know

Current Medications ☐None

☐ I take these prescription or over the counter medications:

Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____
Name: _____ Dose _____

Use the back of this form if more room is needed

Allergy / Reaction

☐ No Known Allergies
☐ Penicillin _____
☐ Shellfish _____
☐ Sulfa _____
☐ Tape _____
☐ Latex _____
☐ Betadine *(iodine)* _____
☐ Aspirin _____
☐ Tylenol™ _____
☐ Ibuprofen _____
☐ Codeine _____
☐ Other *(specify)* _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. _____ *(Patient Signature)*

EMAIL: _____

Practice: LOMBARDI AND SILVER, LLP

Today's Date:

Name: _____ DOB: _____ Chart Number: _____

Sex: ☐M ☐F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced SS#: _____

E-mail: _____ Spouse/Partner Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Pharmacy: _____ Phone: _____

Primary Care Physician: _____ Phone: _____ Date Last Seen: _____

Address: _____

Employer: _____ Phone: _____

Address: _____

Primary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____

Secondary Insurance: _____ Are you the insured? ☐Yes ☐No

Insured Information

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend

☐ Other: _____

What is the reason for your visit today? _____

_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

What treatments have you tried & have they been effective? _____

_____

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling other:_____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. X _____ (Patient Signature)