PATRICK K. SULLIVAN, MD

PATIENT INFORMATION

Please bring all insurance information on the day of the appointment - Thank You

APPOINTMENT DATE: _____

Patient's Name: (Last) _____ (First) _____

Parents Name (for minors) _____

Date of Birth _____ Age _____ Sex: **M / F** Soc. Sec # _____

Address: _____

City/Town _____ State _____ Zip _____

Home Phone ( ) _____ Cell ( ) _____ Work ( ) _____

Email Address _____

May we use your email address to contact you regarding your medical care with our office? ***Y*** ***N*** Please Circle

May we use your email address to contact you regarding E Newsletters and/or other mailings? ***Y*** ***N*** Please Circle

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship _____

Address: _____ City/State _____, _____ Zip _____

Home Phone ( ) _____ Cell ( ) _____ Work ( ) _____

EMPLOYER: (if patient is a minor, parent's place of employment needed)

Name: _____ Address: _____

Telephone Number ( ) _____ _____

*** REFERRAL SOURCE:** _____

(Friend, Salon, Physician, Newspaper, Word of Mouth, Yellow Pages, etc.)

Name: _____ Telephone #: ( ) _____

Address: _____

** May we be in contact with the person(s) who referred you to us? **YES / NO** Initial _____

Please circle one

PRIMARY CARE PHYSICIAN: _____

Address: _____ Phone: ( ) _____

Assignment of Benefits:

I, the undersigned, hereby authorize payment of medical and surgical services be paid directly to Patrick K. Sullivan, MD.
I, the undersigned, hereby authorize any holder of medical information about the above patient to be released to the Health Care Financing Administration and it's agents any information needed to determine benefits payable for related services.

_____ _____

Patient/Parent/Guardian Signature **Date**

Statement of Financial Responsibility

I, the undersigned, have read the above and realize that all medical and surgical charges incurred by me or my dependants for services rendered by Patrick K. Sullivan, MD are my financial responsibility. All court fees, or other fees necessary to collect this account are payable to the Doctor's office.

_____ _____

Patient/Parent/Guardian Signature **Date**

Notice of Receipt of the "NOTICE OF PRIVACY PRACTICES"

I hereby acknowledge that I have received the "Notice of Privacy Practices" from the office of - Patrick K. Sullivan, MD

Patient/Parent/Guardian Signature **Date**

PATRICK K. SULLIVAN, MD

PATIENT HISTORY

Please use the back of this form if you need additional space to completely answer any of the following questions.
Please complete as accurately and completely as possible - Thank You

In your own words, what would you like to see Dr. Sullivan about? *(Please be as specific as possible)*

_____

How long have you have you been concerned about this? _____

Have you had any previous treatment for this condition? **YES / NO**

If YES, **how and when** was this treated? _____

_____

Have you ever had surgery: **YES / NO** If Yes, **Please explain in detail:** ***(Include Surgeon's Name)***

_____

_____

Do you Currently take blood thinners? (Such as Aspirin, Coumadin or Plavix) **YES / NO**

Do you have an allergy to Latex? **YES / NO** Do you have an allergy to soy or nuts **Yes / No**

Do you have a history of MRSA? **YES / NO**

Do you have any **ALLERGIES** to Medications/Food: **YES / NO** If Yes, **Please List ALL and explain how it affects you:**

Name: _____ Symptoms: _____

Name: _____ Symptoms: _____

Your medications are VERY IMPORTANT - Please list **ALL** medications you are currently taking, either prescription or over the counter (i.e., aspirin, birth control, vitamins, etc.)

MEDICATION NAME:	DOSAGE:	HOW OFTEN:	PRESCRIBED FOR:

Have you had **ANY** of the following: **(PLEASE CIRCLE YES OR NO FOR EACH)**

Breathing Difficulties:	**YES / NO**	Unexplained Bleeding Problems:	**YES / NO**
Shortness of Breath:	**YES / NO**	Family member with unexplained bleeding problems:	**YES / NO**
Thyroid Problems:	**YES / NO**	Diabetes:	**YES / NO**
Chest Pain:	**YES / NO**	Stomach Problems:	**YES / NO**
Strokes:	**YES / NO**	Cancer:	**YES / NO**
Seizures:	**YES / NO**	Skin Cancer:	**YES / NO**
Heart Attack:	**YES / NO**	Nose/Throat Problems:	**YES / NO**
High Blood Pressure:	**YES / NO**	Ear/Eye Problems:	**YES / NO**
Do you have any other medical		Deep Vein Thrombosis (DVT):	**YES / NO**
problems?	**YES / NO**	Pulmonary Embolis (PE):	**YES / NO**

*If you answered YES to any of the above questions, please explain in detail below. List **ALL** current/past treatments.*

_____

_____

_____

Height: **Weight:**

Do You Currently Smoke: **YES / NO** Packs per day?____

Do You Drink Alcohol: **YES / NO** How Much?_____ How Often?_____Type_____

_____ _____ _____/_____/_____

Patient: ***(signature)*** Relationship (if not patient)