DATE_____________

old greenwich medical group
oldgreenwichmedicalgroup.com

NEW PATIENT INFORMATION

PATIENT NAME ____ SEX: M F DOB__________________________

ADDRESS ____

HOME PHONE (______)_______________WORK (______)___________________CELL (______)___________________

SOCIAL SECURITY ___________________________ EMAIL ADDRESS_________________________________

PATIENT EMPLOYMENT ____
BUSINESS ADDRESS/PHONE ____

MARITAL STATUS (circle): Married/Divorced/Widowed/Single
NAME OF SPOUSE/SIGNIFICANT OTHER______________________________ WORK #__________________________

EMERGENCY CONTACT PERSON__________________________________PHONE_____________________________

HOW WERE YOU REFERRED TO OUR OFFICE? ____

SMOKING HISTORY: (circle) Yes-currently; Yes-quit; No/Never. IF YES, How Much?__________ How Long?__________

DO YOU DRINK ALCOHOL? ____________ IF YES, HOW MUCH?____

MEDICAL HISTORY (include Injuries, Hospitalizations, Surgeries, Medical Problems, Major Illnesses)
____
____
____
____
____

LIST OF MEDICATIONS (include Herbal/Vitamin supplements, Birth Control pills)
____
____
____
____

ALLERGIES (to Medications)____

MAY WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE? YES_______ NO_________

BEST WAY TO BE REACHED DURING THE DAY WITH TEST RESULTS____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

SIGNED____DATE_________________________________