Welcome To Our Office

Patient Name:_____
Date of Birth (aa/aa/aaaa):_____
Gender (M/F/T) :_____ Race: _____
Address:_____City:_____
State:_____
Zip Code:_____
Best Contact Phone Number:_____
Email:_____@_____

Emergency Contact

Please Notify (Name):_____
Relationship to patient (husband, wife, child, POA, etc):_____
Emergency Contact Phone Number:_____
Can we discuss your medical results with the emergency contact person? Yes☐ No☐

Insurance Information

Insurance Company:_____
Guarantor Name:_____
ID Number:_____
Group Number:_____
Is Patient Covered by Any Additional Insurance? Yes☐ No☐
If Yes, what is additional insurance company:_____
ID Number:_____
Group Number:_____

HIPPA Agreement

I,_____ , (print name) certify that I have read and agree with the HIPPA privacy form located on https://midwestinternal.com/patient-information/.

Signature of Patient, Guardian, or personal Representative:_____
Date☐☐/☐☐/☐☐☐☐

Medical Information

Allergy List:

Allergen (Ex: dust)	Type of Reaction	How it's Treated (any medications)

Current Immunization:

Vaccine Name	Date Received (approximate)

Current Medications:

Name of Medication	Dosage	Frequency Taken	Reason for Taking	Prescribing Physician

Supplement List:

Supplement Name	Dosage	Frequency Taking	Reason for Taking

Pharmacy Information

Pharmacy Name:_____

Cross Streets:_____

Address:_____ City: _____ State:_____