

Do you have any medical problems that have not been covered?

Do you smoke cigarettes? _____ How much? _____
Do you drink alcoholic beverages? _____ Socially _____ Daily _____
Do you take any recreational drugs? _____
Patient height _____ Patient Weight _____
Do you take any diet medication? _____

II. MEDICAL HISTORY

Name and city of your personal physician _____
Are you presently under the care of a physician for any medical condition?

A. SURGICAL HISTORY- Please list all previous surgeries (including cosmetic)

Operation	Name of Surgeon	Date of Surgery
_____	_____	_____
_____	_____	_____

B. HOSPITALIZATION (Others than for surgery)

Illness	Physician/Date
_____	_____
_____	_____

III. MEDICATIONS & VITAMINS/DIETS PILLS

Name of Drug	Strength/Dosage	Condition Treated
_____	_____	_____
_____	_____	_____

IV. ALLERGIES: (Please list any allergies to any medications, tapes, or antiseptic cleansers)

V. FAMILY HISTORY: (Please indicate if any immediate family member has ever had any of the following?)

Heart Disease	___	Bleeding Disorder	___
Diabetes	___	Autoimmune Disease	___
Anesthetic Complication	___	Others	___

ASSIGNMENT OF BENEFITS:

I hereby authorize the Insurance Company to pay by check made out and mailed directly to _____ the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I agree to pay in current manner, any balance of said Professional Service charges over and above this insurance payment.

Patient Signature

Date

Witness

Date