THE MODERN MEDICINE GROUP

Patient Demographics

Date _____

Patient Information:

First Name	Middle Name / MI	Last Name	Sex
Date of Birth	Home Phone	Cell Phone	Preferred Phone
Patient Address Line 1	Patient Address Line 2		
City	State	Zip	
Email	Language	Communication Preference	Ethnicity
Religion	Race	Marital Status	
Spouse's Name	Spouse's Contact Phone		
Patient Employment Status	Professional Title	Employer Name	
Work Phone	Fax Number		
Employer Address Line 1	Employer Address Line 2		
Employer City	Employer State	Employer Zip	

Primary Insurance Information:

Primary Insured's Name	Date of Birth	Primary Relationship to Insured	Primary Insured's SSN
Insured's Home Phone	Cell Phone	Work Phone	Driver's License #
Primary Insurance Name	Primary Plan Name	Primary Subscriber ID	Primary Group No.

Secondary Insurance Information:

Secondary Insured's Name

Date of Birth

Secondary Relationship to Insured

Secondary Insured's SSN

Insured's Home Phone

Cell Phone

Work Phone

Driver's License #

Secondary Insurance Name

Secondary Plan Name

Secondary Subscriber ID

Secondary Group No.

Emergency Contact:

Emergency Contact Name

Emergency Contact Relationship to Patient

Emergency Contact Home Phone

Emergency Contact Cell Phone

Emergency Contact Work Phone

Emergency Contact Address Line 1

Emergency Contact Address Line 2

Emergency Contact City

Emergency Contact State

Emergency Contact Zip

Primary Physician Name

Primary Physician Phone

Whom may we thank for referring you?

Health History

Current medical conditions:

Month/Year Diagnosed	Medical Problem	Treatment/Medication
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Surgeries:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Hospitalizations:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Medications:

Name of Drug	Strength	Frequency Taken
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Allergies:

Name	Reaction
1)	_

2) _

3) _

4) _

Exercise:

Type	Intensity	Frequency
Type	**Intensity**	**Frequency**

Social History

Caffeine:

Caffeine Beverage?	Type (coffee, tea, soda, etc.)	Amount	Frequency
◯ Yes ◯ No			

Alcohol:

Alcoholic Beverage?	Frequency	Amount
◯ Yes ◯ No		

Smoking Status:

Patient Smoking Status	Patient Smoking Frequency	Patient Smoking Start Date	Patient Smoking End Date

Do you currently use recreational or street drugs?

◯ Yes
◯ No

Have you ever given yourself street drugs with a needle?

◯ Yes
◯ No

Family History

List medical illness and/or cause of death:

Mother

_____

Father

_____

Brother/Sister

_____

Husband/Wife

_____

Son/Daughter

_____

Additional Comments

_____

Signature of Responsible Party

Date

_____