PATIENT INFORMATION * PLEASE PRINT *

DATE: _____ SOC.SEC # _____ BIRTHDATE: ____/____/_____

NAME: _____ HOME # _____

ADDRESS: _____ CELL # _____

CITY: _____ STATE: _____ ZIP: _____ EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____ WK # _____

EMERGENCY CONTACT: _____ PHONE # _____

WHO MAY WE THANK FOR REFERRING YOU? _____

MEDICAL HISTORY

Physician's Name: _____ Phone # _____ Date of last visit: _____

1. Are you currently under medical treatment? Yes or No
2. Have you ever had any serious illnesses or Yes or No
   Or operations? Please list below
   _____
3. Are you currently taking any medication? Yes or No
   Please describe: _____
   _____
4. Do you smoke? Yes or No
5. Do you use alcohol Yes or No
6. Do you wear contact lenses? Yes or No
7. Have you had any allergic reactions to:
   - Local Anesthetics (e.g. Novocain) Yes or No
   - Penicillin or other Antibiotics Yes or No
   - Sulfa Drugs Yes or No
   - Barbiturates (sleeping pills) Yes or No
   - Sedatives Yes or No
   - Iodine Yes or No
   - Aspirin Yes or No
   - Other: _____
8. Women- Are you: Pregnant? Y or N Nursing? Y or N
   Taking Birth Control? Y or N

Please circle all that apply:

AIDS
Anemia
Arthritis, Rheumatism
Artificial Joints
Asthma
Back Problems
Bleeding abnormally
Blood Disease
Cancer, Type _____
Chemical Dependency
Chemotherapy
Chronic Fatigue Syndrome
Circulatory Problems
Congenital Heart Lesions
Cortisone Treatments
Cough-persistent or bloody
Diabetes
Emphysema
Epilepsy
Fainting or Dizziness
Glaucoma
Headaches
Heart Murmur
Heart Problems
Hepatitis- Type _____
Herpes
High Blood Pressure
HIV positive
Jaundice
Jaw Pain
Kidney Disease
Latex Sensitivity
Liver Disease
Low Blood Pressure
Mitral Valve Prolapse
Pacemaker
Psychiatric Care
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Shortness of Breath
Sinus Trouble
Skin Rash
Stroke
Swelling of Feet/Ankles
Swollen Neck Glands
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor or growth on head/neck
Ulcer
Venereal Disease

ASSIGNMENT AND RELEASE

I hereby understand that I am financially responsible for all charges, whether or not paid by my insurance and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date: _____

I hereby authorize payment directly to Dr. Manduzzi for all insurance benefits otherwise payable to me for services rendered.