DUNCAN C. RAMSEY III MD

Account #_____ Referred by _____

Last Name_____First Name_____Middle _____

DOB_____Age_____Social Security_____DL# _____

ADDRESS _____

CITY_____STATE_____ZIP _____

Phone HOME_____CELL_____WORK _____

Email Address_____

Marital Status Single_____Married_____Divorced_____Widowed _____

Spouse's Name_____Spouse's phone _____

Patient Employer _____

Responsible Party Name _____

Relationship to Responsible Party: Self_____Spouse_____Child _____

Emergency Contact_____Phone_____ Relationship _____

If patient is a minor, please fill out the following:

Father's Name _____ Address _____ Phone _____

Father's Employer _____ Occupation _____ Business Phone _____

Mother's Name _____ Address _____ Phone _____

Mother's Employer _____ Occupation _____ Business Phone _____

Insurance Information
Primary_____Group #_____ID # _____

Employer if Group Coverage _____

Secondary_____Group #_____ID # _____

Relationship to subscriber: Self_____Spouse_____Child _____

SIGN FOR AUTHORIZATION FOR RELEASE OF INFORMATION OR ASSIGNMENT OF BENEFITS PAYABLE TO DOCTOR FOR INSURANCE OR MEDICAL BENEFITS. PAYMENT IN CASH, CHECK OR CREDIT CARD IS DUE AT THE TIME OF SERVICE. PLEASE PRESENT YOUR CURRENT INSURANCE CARD.

SIGNATURE_____DATE _____

DUNCAN C. RAMSEY III MD

Last Name_____First Name_____MI _____

Date of Birth_____Age_____Social Security_____Sex: M_____F _____

Who is your primary physician?_____Physician Phone_____

Patient's Height_____Weight _____

Please check all that apply to the patient:

- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Angina
- ☐ Heart Burn
- ☐ Heart Disease
- ☐ Bleeding Tendencies
- ☐ Heart Attack
- ☐ Hiatal Hernia
- ☐ Thyroid Problems
- ☐ Breathing Problems
- ☐ Recent Cold/Flu
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Liver Problems
- ☐ Hepatitis (which type, if known) _____
- ☐ Bleeding Tendency
- ☐ Hemophilia
- ☐ Anemia
- ☐ Migraine Headaches
- ☐ Nerve Injury
- ☐ Seizure
- ☐ Stroke
- ☐ Rheumatic Fever
- ☐ Kidney Problems
- ☐ Diabetes
- ☐ Cancer

Please explain any of the checked boxes above: _____

_____

Current Medications: _____

List Previous Surgeries: _____

Please check if they apply: Do you have a family history of: Diabetes_____Stroke or Heart Attack _____
Cancer_____Anesthesia problems _____
If checked, please explain _____

Drug Allergies: _____

Tobacco Use: Yes_____No_____Amount:_____packs per day for_____Years

Do you drink alcohol? Yes_____No_____If yes, how much in a typical day? _____
Recreational Drug Use: _____

Could you be pregnant? Yes_____No_____Start date of last menstrual cycle _____

I have completed and read this questionnaire and answered truthfully to the best of my knowledge. I am aware my answers affect my health care or that of the patient for whom I am responsible.

Signature_____Date_____