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 _____

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 OR CHECK 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_____