# HEALTHSOURCE SAGINAW PATIENT INFORMATION

*Insurance Card and Photo ID required

DATE: _____ AGE: _____ DOB: _____

NAME: _____ MALE ____ FEMALE____

ADDRESS: _____
Address City State Zip Code

PHONE #: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____PHONE #: _____

DATE OF RETIREMENT:_____

MARITAL STATUS: SINGLE MARRIED SEPERATED DIVORCED WIDOWED
(Circle One)

## SPOUSE INFORMATION

SPOUSE'S NAME: _____ DOB: _____ SSN: _____

EMPLOYER: _____ PHONE #: _____

## CONTACT INFORMATION

PERSON TO CONTACT IN CASE OF EMERGENCY_____

PHONE #: _____ RELATIONSHIP: _____

PERSON WHO WILL BE TRANSPORTING YOU TO AND FROM THERAPY

NAME: _____ PHONE #: _____

YOUR DOCTOR'S NAME: _____PHONE #: _____

WHICH HOSPITAL WOULD YOU WANT TO GO TO IN CASE OF AN EMERCENCY?

_____

## MEDICAL HISORY

MEDICINES YOU ARE NOW TAKING:

1._____

2._____

3._____

4._____

ALLERGIES: COMMENTS:

1._____

2._____

3._____

4._____

Over →

I NOW HAVE, OR HAVE HAD IN THE PAST: (PLEASE CHECK ALL THAT APPLY)

| | Have Now | Had In the Past | | Have Now | Had In The Past |
|---|---|---|---|---|---|
| ASTHMA | | | ARTHRITIS | | |
| ANEMIA | | | HEART TROUBLE | | |
| BLOOD CLOTTING PROBLEMS | | | HIGH BLOOD PRESSURE | | |
| DIABETES- "SUGAR" | | | GOUT | | |
| CANCER | | | EMPHYSEMA | | |
| SEIZURES | | | THYROID DISEASE | | |
| GLAUCOMA | | | LIVER DISEASE | | |
| KIDNEY OR BLADDER PROBLEMS | | | STROKE | | |
| STOMACH ULCER | | | TB | | |
| NERVE PROBLEMS | | | OTHER: LIST BELOW | | |

1._____2._____3._____

Prior to your illness were you, right or left handed? Right_____ Left_____

OPERATIONS YOU HAVE HAD (START WITH THE MOST RECENT FIRST):

1._____2._____

3._____4._____

_____
SIGNATURE OF PATIENT

_____
SIGNATURE OF RESPONSIBLE PARTY