Head to Toe Family Healthcare

735 North 5th Street Silsbee, TX 77656
Phone (409)385-6500 Fax (409)385-6505

PATIENT DEMOGRAPHIC

TODAY'S DATE: _____

PATIENTS NAME: _____ **DATE OF BIRTH:** _____

Current Mailing Address: _____

Home Phone: ( ) - _____ **Cell Phone: ( ) -** _____ **Work Phone: ( ) -** _____

Emergency Contact: _____ **Cell Phone: ( ) -** _____ **Social Security No.** _____

Employers Name: _____ **Work Phone: ( ) -** _____

Location

Responsible Party: _____ **Phone: ( ) -** _____

Family Doctor: _____ **Phone: ( ) -** _____

Location

Primary Insurance: _____ **Policy No:** _____ **Group No.** _____

Name of Insured: _____ **Relationship:** _____ **THEIR Date of Birth.** _____

Secondary Ins: _____ **Policy No:** _____ **Group No.** _____

Name of Insured: _____ **Relationship:** _____ **THEIR Date of Birth.** _____

PATIENT MEDICAL HISTORY

Date of Last Physical Exam: _____ **Physician who Performed Exam:** _____

Medical Conditions (Please Circle All That Apply):

Asthma	Lupus	Nervous Condition	Migraines	Pacemaker	Arthritis	Heart Condition
Hepatitis	Blood Clots	Irregular Heartbeat	Bronchitis	Diabetes	Emphysema	Sleep Apnea
Cardio Stent	Stroke	High Blood Pressure	COPD	Cancer	Heart Attack	Heart Murmur
Fibromyalgia	CHF	Vascular Disease	Anemia	Thyroid	Ulcers	Kidney Problems
MS/MD	Liver Problems	Shortness of Breath	Cardiac Bypass			

Please list ALL past surgical history: _____

_____

Please list ALL Allergies (medication and/or food): _____

Do You Smoke: _____ **If yes, how much and how often?** _____
Do you Drink: _____ **If yes, how much and how often?** _____
Substance Abuse: _____ **If yes, how much and how often?** _____

Do you have a Family History of: (Please Circle All That Apply):

Osteoarthritis	Rheumatoid	Osteoporosis	Gout	Cancer	Psoriasis	Lyme's Disease
Arthritis	Heart Disease	Diabetes	Lupus	Other: _____		