Name (Last, First Middle) ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr.			Social Security Number
Cell Phone	Home Phone		Work Phone
Address	City	State	Zip
Date of Birth	Sex ❑ M ❑ F	Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed	Age
❑ Employed ❑ Full-time student ❑ Part-time student	Employer and Address		
Name of referring doctor(s) – we'll send a report	#	Fax #	
Onset of current problem	Worker's compensation? ❑	Motor vehicle accident? ❑ State__________	Other accident? ❑
In emergency, contact:		Relationship	Phone

Race: White ❒ Black / African American ❒ Asian ❒ Hispanic ❒ American Indian ❒ Other ❒ Refused To Report ❒

Email: ____

PRIMARY INSURANCE CARRIER			
Insurance Carrier's Address	City	State	Zip
Insured	Relationship ❑ Self ❑ Spouse ❑ Child	Insured's Phone	
ID #	Group #		
Insured's SS #	City	State	Zip
Insured's Date of Birth	Insured's Sex ❑ M ❑ F	Insured's Employer	

OTHER INSURANCE CARRIER ______________________________

Insurance Carrier's Address ____________________ City________________ St _____ Zip _____

Insured __________________________ Relationship ❒ Self / ❒ Spouse / ❒ Child

ID# ______________ Group # ____________ Insured's Phone Number ____________________

Insured's Address________________________ City________________ St _____ Zip _____

Insured's Date of Birth __________ Insured's Sex ❒ M ❒ F Insured's Employer ____________________

In consideration of the examination to be provided by SFSS, LLC physicians. I understand that the doctor makes no representations about my condition other than those concerning the problem for which he has been retained. I assign any benefits received from my insurer to SFSS, LLC physicians. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is also valid. I authorize release of all information necessary to secure payment. Should the doctor's testimony be required with regard to my case, I agree to be responsible for a $250.00 per hours fee for testimony and preparation I agree to pay any deductible or other balance not paid by my insurer. I understand that a monthly charge of 1% (12% annual rate 12%) and collection costs including attorney's fees may be charged on overdue payments.

Patient's Signature ____________________________________ Date____________________

IMPORTANT: Please answer the medical questions on the back of this page.

Patient ______________________________

Year	Doctor or hospital	Nature of problem

To what drugs are you ALLERGIC? ☐ None known

PHARMACY NAME:
ADDRESS:

Y	N	Cigarette smoking: ☐ past ☐ present	Y	N	Swollen glands
Y	N	Alcohol abuse: ☐ past ☐ present	Y	N	Loss of appetite
Y	N	Drug abuse: ☐ past ☐ present	Y	N	Unintentional weight loss
Y	N	Fever or chills	Y	N	Abdominal pain
Y	N	Easy bruising or bleeding	Y	N	Nausea or vomiting
Y	N	Blood transfusions	Y	N	Recent change in bowel habits
Y	N	Dizziness	Y	N	Rectal bleeding or black stools
Y	N	Fainting or blackouts	Y	N	Jaundice (yellowing of skin or eyes)
Y	N	Double vision	Y	N	Difficulty voiding
Y	N	Transient visual loss	Y	N	Blood in urine
Y	N	Paralysis	Y	N	Backache
Y	N	Numbness	Y	N	Joint pain, swelling, stiffness
Y	N	Shortness of breath	Y	N	Leg pain
Y	N	Wheezing or asthma	Y	N	Leg fatigue when walking
Y	N	Coughing of blood	Y	N	Leg cramps at night
Y	N	High blood pressure	Y	N	Varicose veins
Y	N	Chest pain	Y	N	Phelebitis or inflamed vein
Y	N	Palpitations	Y	N	Ankle swelling
Y	N	Heart murmur	Y	N	Injury
Y	N	Breast lump or nipple discharge	Y	N	Men: Loss of sexual activity
Y	N	Mother, grandmother, aunt with breast cancer	Y	N	Women: Missed or abnormal period

Reviewed by ______________________________, MD