R. S. PALUTSIS, M.D.
DAVID V. MUNGO, M.D.
DAVID A. KANAGY, M.D.

THE CARNATION CLINIC, INC.

1401 SOUTH ARCH AVENUE
ALLIANCE, OHIO 44601
PHONE 330-821-0201 • FAX 330-821-1924

REED B. GRAHAM, D.P.M.

ROBERT E. LEE, M.A., CCC/A

NEW PATIENT INFORMATION (PLEASE PRINT) **DATE** ______________________

PATIENTS NAME			MARITAL STATUS S M W D SEP	DATE OF BIRTH	AGE	S.S.#
STREET ADDRESS	PERMANENT	TEMPORARY	CITY AND STATE		ZIP CODE	HOME PHONE#
PATIENT OR PARENT'S EMPLOYER			OCCUPATION (INDICATE IF STUDENT)		BUS. PHONE#	
EMPLOYER'S STREET ADDRESS			CITY AND STATE			ZIP CODE
SPOUSE OR PARENT'S NAME			NUMBER OF CHILDREN AND AGES			
DATE OF INJURY/ONSET OF SYMPTOMS			SIDE INVOLVED		L OR R HANDED	IS THIS WORK RELATED?
FAMILY MD			HOW DID YOU HEAR ABOUT OUR OFFICE?			
WHAT BRINGS YOU HERE? / CHIEF COMPLAINT?						

LIST TESTS OR TREATMENTS YOU HAVE HAD DONE FOR THIS PROBLEM
1. MEDICATIONS 2. PHYSICAL THERAPY 3. X-RAYS OR TESTS

____
____
____
____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS (CIRCLE ALL APPROPRIATE AND EXPLAIN BELOW)
CARDIOVASCULAR: HEART DISEASE, HIGH BLOOD PRESSURE, VALVE DISEASE, STROKES
PULMONARY: ASTHMA, PNEUMONIA, TUBERCULOSIS, SNORING/SLEEP APNEA
GASTOINTESTINAL: HEPATITIS, ULCERS, PANCREATITIS, COLITIS
GENITOURINARY: KIDNEY STONES/DISEASE FREQUENCY/PROSTATE PROBLEMS, FREQUENT UTI's
MENSTRUATING? (YES or NO)
HEMATOLOGIC: BLEEDING PROBLEMS, BLOOD CLOTS, BRUISE EASILY, VEIN PROBLEMS, ANEMIA
NEUROLOGIC: SEIZURES, NEUROPATHY NUMBNESS/TINGLING OF EXTREMITIES
ENDOCRINE: THYROID DISEASE, DIABETES, UNEXPECTED WEIGHT LOSS or GAIN
MUSCULOSKELETAL: BROKEN BONES, ARTHRITIS
OTHER:

PAST SURGICAL HISTORY (Circle all those appropriate and given dates)
HEART SURGERY/BYPASS SURGERY, GALL BLADDER, APPENDIX, HERNIA, TONSILLECTOMY, TUBAL
C-SECTION, URINARY/BLADDER/KIDNEY SURGERY, PROSTATE, JOINT SURGERY (Replacement/Arthroscopy)
SINUS, EAR SURGERY, OTHER ____
____
____

LIST ALL MEDICATIONS AND DOSES IF KNOWN (Include perscription, over the counter and suppliments)

____

ALLERGIES TO MEDICATIONS (Please list) ARE YOU ALLERGIC TO LATEX? Yes ❑ No ❑

PERSONAL HISTORY

Do you smoke? (Yes/No) __________ Packs a Day for __________ Did you used to smoke? __________

When did you stop? ______________________________

Alcohol Use: Never ❑ Occasional ❑ Frequent ❑ Drug Use (Yes/No) _______

BSP #143 2-sd 2-hl tumble-h 12-05

OVER →

FAMLIY HISTORY	Alive Yes or No	Ages	Medical Problems
Mother			
Father			
Brothers			
Sisters			
Children			
Is there any family member with a serious reaction to anesthesia?			

INSURANCE INFORMATION

Primary Insurance	Name of Insurer
Policy Number/ID	Insured Date of Birth
Group Number	Insured SSN
Effective Date	Insured Address Insured Phone
Co-Pay Amount	Relationship to Patient

Secondary Insurance	Name of Insurer
Policy Number/ID	Insured Date of Birth
Group Number	Insured SSN
Effective Date	Insured Address Insured Phone
Co-Pay Amount	Relationship to Patient

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE ______________________________ M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE ____________________ SIGNATURE ____

Notes: