PATIENT INFORMATION FOR DR. MICHAEL X. ROHAN

Patient_____
(LAST NAME) (FIRST NAME) (MI) (AGE) (BIRTHDATE)

Mailing address:_____ Permanent Address_____
Street Street

_____ _____
City State Zip City State Zip

Phone_____ Social Security:_____

Occupation:_____ Spouse's Name:_____

Employer:_____ Spouse's Employer:_____

Employers Address:_____ Employers Address:_____

_____ _____

Telephone:_____ Telephone_____

Insurance: (check one)

Medicare_____ Medicaid_____ Workers Comp_____ Medical Insurance_____ None_____

_____Tricare _____Vocational Rehab

Name of Insurance Company:_____

Address:_____

Policy#:_____ Group#_____

Drug Allergies_____

Smoker? Yes_____ No_____ Next of Kin:_____

Referred by:_____ Relationship:_____

Telephone:_____

AUTHORIZATION TO PAY

_____ hereby authorize _____
(Name of Insured) (Name of Company)

to pay directly to Michael X. Rohan, M.D. the surgical and or medical benefits, if any, otherwise payable to me for his services, but not to exceed the charges for those services. I understand that I am financially responsible for those charges not paid by my insurance company.

Date_____ Signed_____

CASH PATIENTS

I understand that I am financially responsible for all charges relating to medical care provided by Dr. Michael X. Rohan

Date_____ Signed_____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize release of information concerning my treatment to Dr. Michael X. Rohan, M.D.

Date_____ Signed_____

Patient Information Sheet

Name _____ Date_____

Right handed_____
Left handed_____

Allergies:

Present Medications:

Prior operations:

Review of Systems:

General (circle those that apply)

Generally healthy	Overweight	Weak
Active	Inactive	Fatigued

Wt. Gain or Loss in past year-----

Head/Eyes/Ears/Nose & Throat (circle those that apply)

Head injury	Headaches	Nosebleeds
Hearing aid	Hearing loss	Frequent Colds
Ringing in ears	Loss of balance	Sinus problems
Sore throats	Mononucleosis	

Cardiovascular (circle those that apply)

Chest pain	Shortness of breath	Angina
Smoke x ___ years	High blood pressure	Swelling of arms or legs

Respiratory (circle those that apply)

Frequent coughs	Wheezing	Coughing up blood
Pneumonia	Oxygen use	

Gastrointestinal (circle those that apply)

Indigestion	Heartburn	Ulcers
Hernias	Liver Disease	Nausea
Hepatitis	Food intolerance	Abnormal bleeding

Genitourinary (circle those that apply)

Infections	Blood in urine	Painful urination
Kidney stones	Cystitis	Flank pain

Ob/Gyn (circle those that apply)

Pelvic pain	Irregular menses

Endocrine (circle those that apply)

Diabetes	Thyroid problems	Osteoporosis
Hot flashes	Excessive thirst	Hair loss

Immune System (circle those that apply)

HIV	Aids

Vascular (circle those that apply)

Phlebitis	Aneurysms	Blood clots

Skin (circle those that apply)

Rashes	Dry skin	Hair problems
Nail problems	Easy bruising	

Breast (circle those that apply)

Lumps Operations Masses

Family History

Mother

_____cancer
_____diabetes
_____heart attack
_____other

Father

_____cancer
_____diabetes
_____heart attack
_____other

Employment History

_____Employed
_____Unemployed
_____Retired
_____Disabled

Social History

_____Married
_____Single
_____Divorced

Alcohol use

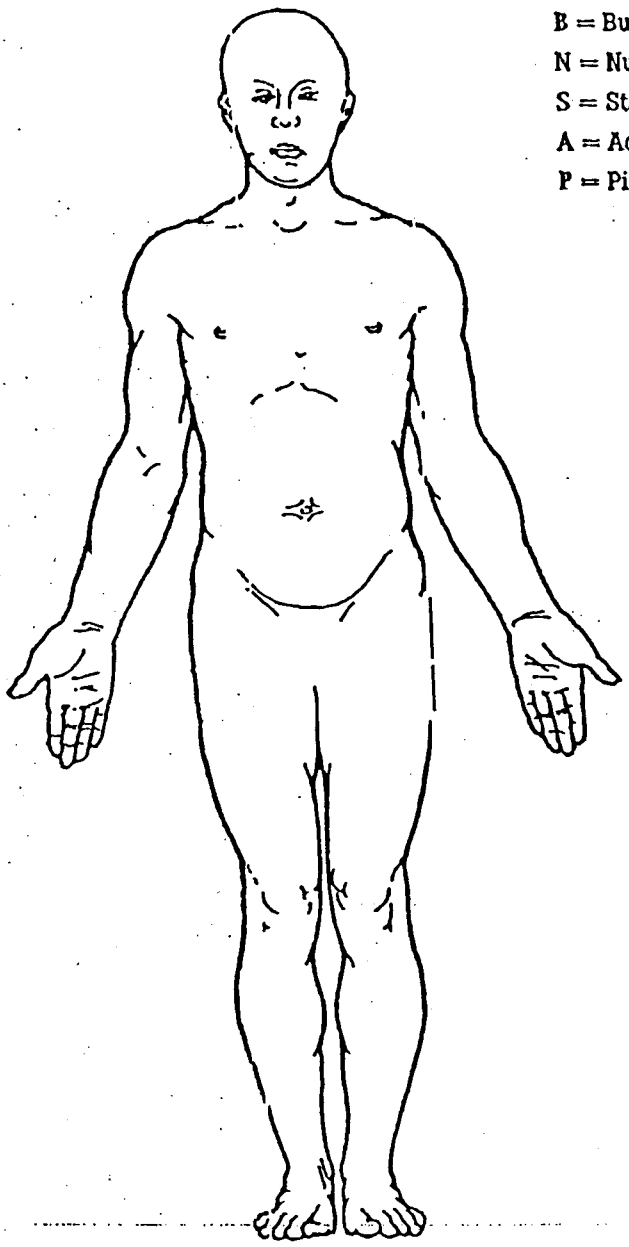
_____None
_____Mild
_____Moderate

Patient Intake Form

Pain Diagram

The information you provide on this form will be useful to the consultant(s) you will be seeing today and will help your exam go smoothly and as quickly as possible. If you are being evaluated for a painful condition, mark the drawings below according to how you feel today. Use the figure labeled "Back" for pain on the back of your body. If you have any of the symptoms shown in the diagram, indicate where they are by writing in the following letter on the affected body part:

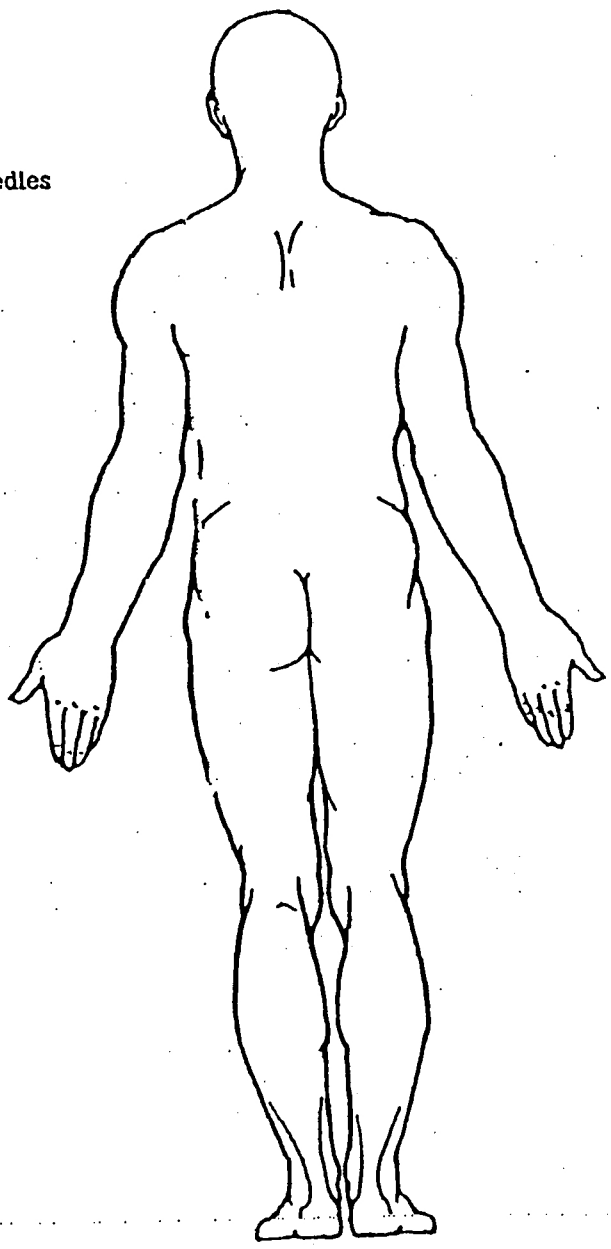
Front



Types of Pain

B = Burning
N = Numbness
S = Stabbing
A = Aching
P = Pins & Needles

Back



Please complete this section.

Your name_____ SS#_____ Today's date_____

Height_____ Weight_____ Birth date_____ Age_____

Claim#_____

Thank you for completing this pag

Chief complaint _____