

This is a sample form and is only meant to show what can be done. Please make up all of your answers.

Your form name and instructions will go in this area.

Clinic
Logo
Here

PATIENT INFORMATION AND HISTORY

All sections of this form must be completed. Signature block(s) must be either digitally or physically signed and dated. The digitally signed pdf can be emailed to **office-email-address.com** or print and bring an electronically filled out version with you to your appointment. Use the buttons at the bottom of this form. To move from field-to-field press the TAB key or just click on the field you need to fill out.

PATIENT INFORMATION

| | |
|-----------------------------------|-------------|
| Patient Last Name: | First Name: |
| If a minor, guardian's Last Name: | First Name: |
| Billing Address: | |
| City: | State: |
| County: | Zip: |
| Best Contact Phone #: | Email: |
| Other Phone: | |

INSURANCE INFORMATION

| | |
|-------------------------|--------------------------|
| Insurance Company: | Name of Insured: |
| Insurance Group Number: | Insurance Policy Number: |

PATIENT INFORMATION

Are you currently, and/or have you had in the past or a family history of any of these:

| <i>CURRENTLY In The Past or Family History</i> | <i>CURRENTLY In The Past or Family History</i> |
|--|--|
| Dizziness | Seeing Spots |
| Skin Rash | Tooth Pain |
| Headaches/Migraines | Frequent Cavities |
| Sore Joints | Gum Sores |
| Sore Throat | Loss of Feeling |
| Ear pain | Tingling in the Hands/Feet |
| Loss of Hearing | Ringling in the Ears |
| Blurred Vision | Other Common Problem |
| Diabetes | Other Common Problem |
| High Blood Pressure | Other Common Problem |
| Broken Bones | Other Common Problem |
| An operation | Other Common Problem |

This is just a sample of a form. Your form will be based on the form(s) you currently use, and on your needs. Bonus: you will be able to make any changes you've been meaning to make to your current form.

When opened in the free Adobe Acrobat Reader application, this form can be easily filled out electronically. Patients can move from field-to-field by pressing the TAB key or by clicking. The check boxes must be clicked on to be checked.

Once filled out, the form can be emailed to a designated email address. Often offices set up a specific email just to receive these forms. The email address will also be listed on the form.

This is a working form for you to try. You can fill out the boxes, save it, print it, and even email it. This one goes to my email (tim@timrogan.com) so you can send a practice one if you wish. I'll gladly print it out and bring it to you so you can see what the finished product will look like.

This form also allows a digital signature if you wish to have it.

The form is totally customizable to your needs and can be as many pages as you need it to be.

Legal information about guaranteeing payment, insurance, etc.

| |
|-------------------------|
| Digital Signature/Date: |
| Type Name: |

SAVE FORM: This will save a completed copy of the form to your computer.

PRINT FORM: Print to bring with you to your appointment or to keep a copy for your records.

EMAIL FORM: This will email the completed form to Doctor's office at **office-email-addresss.com**.