DR. HONG'S NEW PATIENT FORM

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Name: ____ Date: ____________________

Date of Birth: ___________________ Age: ________ Occupation: __________________________

Marital Status: Single: _______ Married ________ Separated ___________ Widower/Widow _________

What is the reason for your visit today? ____

Primary Care Provider Name: _____________________________ Phone #: _______________________________

Other Specialist Name: __________________________________ Phone #: _______________________________

Pharmacy Name: _______________________ Phone#: ___________________________ Zip Code: ___________

MEDICATIONS: List below all medications, vitamins, etc., that you have taken regularly during the past month.

Name & Dosage	How often taken	Purpose Taken

ALLERGIES:

Drug or other allergy	Reactions

Are you allergic to contrast dye or iodine? If so list reaction ____

Do you or have you ever smoked or chewed tobacco? _____ Yes _____ No

If yes: ________ pack/day for ___________ years Date Stopped

Patient Signature____Date________________________

Physician Signature____Date________________________