

PATIENT HISTORY

Generally speaking, are you in good health now? Yes ___ No ___
Do you have a **personal** history of Diabetes? Yes ___ No ___
Is there any **family** history of Diabetes? Yes ___ No ___
Do you smoke? Yes ___ No ___
 If yes, how much? _____
Do you drink alcohol? Yes ___ No ___
 If yes, how much? _____
Are you subject to prolonged bleeding? Yes ___ No ___
 If yes, do you take a blood thinner?
 (Coumadin or Aspirin) Yes ___ No ___
Do you have **allergies** to drugs, medicines or other substances? Yes ___ No ___

If yes, please list: _____

Are you being treated for or have you ever been treated for (please check all that apply):

_____ High Blood Pressure (Hypertension) _____ Liver Disease or Hepatitis
_____ High Cholesterol _____ Epilepsy
_____ Heart Trouble _____ Thyroid Conditions
_____ Circulation issues _____ Syncope (Fainting issues)
_____ Asthma _____ Other (please list): _____
_____ Kidney Disease

Have you had any **serious illnesses** or **operations**? Yes ___ No ___
If yes, what type and when? (please list)

Type _____ Date _____

Do you have a **primary care physician**? Yes ___ No ___

Name: _____

Address: _____

Phone # _____

Date last seen: _____

Are you taking any **medications**? Yes ___ No ___
If yes, please list:

I hereby give permission to Dr. Bass to examine and/or perform diagnostic tests, and treat my condition medically, surgically or orthopedically. The undersigned consents to and authorizes the administration and performance of medical care that may be in the judgment of the physician considered advisable and necessary, why may include the performance of certain blood tests for communicable diseases such as Hepatitis and HIV. Dr. Bass is authorized to furnish information, necessary to process claims, to an insurer, compensation carrier or welfare agency that may be providing financial acceptance for hospital care. I understand that although I have medical insurance, I am solely responsible for payment of medical bills. I agree to pay all fees billed to me immediately upon completion of all services unless other arrangements have been made in advance. I also understand that payment is not dependent upon my insurance.

Signature: _____
Signature of Patient or Legal Guardian

Date: _____

UNDERSTANDING YOUR RESPONSIBILITY

If you have a deductible and you have not met it yet, you may be responsible to pay out of pocket until you have met your deductible. Only then your insurance will start paying for your visits.

If you have a co-pay, it is your responsibility to pay it at the time of your visit.

I _____ **(Print name)** have read and understand my responsibility and am willing to pay any balance and fees on my account, which are not part of my insurance coverage, depending on the plan that I have.

(Signature) _____

(Date) _____