Michael Forman DOM, P.A.
NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Cell Phone (____) ____-_____ Work Phone (____) ____-_____

e-mail address: _____

REFERRED BY: _____

Date of Birth _____ Age ____ Sex: ◉ M ○ F Height ___ Weight ___

Overall health (circle one): ◉ Excellent / ○ Good / ○ Fair / ○ Poor / ○ Other: _____

Chief complaint (reason you are here): _____

_____

_____

Previous treatments for this complain: _____

_____

Current medications/drugs being taken: (use separate sheet if needed) _____

_____

_____

Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):

_____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

HISTORY:

List any major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date: _____

_____

Past Accidents or injuries: _____

_____

Any family history of serious illnesses (circle those which apply):

◉ Cancer / ○ Diabetes / ○ Heart / ○ Other _____

SIGNED: _____ DATE _____