Demographic
Patient Information

Name:____ DOB:__________________________

Address:____

City:____________________________________ State:________________ Zip code:______________________

Home#:_________________________________ Cell#:____

E-mail:____

Employer:____

Emergency contact:_________________________ Emergency Contact Phone #:_______________________

Relationship to patient:____

<u>For Laboratory & Out Patient Services</u>

Health Insurance Company:____

Health Insurance Phone:____

Health Insurance Member ID:____

Health Insurance Group ID:____

X____ Date: ____________________________________
(Signature of patient or guardian if minor)

Patient Information

Name:______________________________ DOB:______________________

Would you like to receive newsletters, promos, or other communication sent by Dr. Sears?
(circle) YES or NO

Employer:______________________________
Emergency contact:____________________ Emergency Contact#:____________________
How did you hear about the practice?______________________________
Reason for today's consultation:
____
What would you like to accomplish with today's visit?
____

Past medical history?
____
____
____
____
____
____
____
____

Do you exercise? (circle) YES or NO
If you do, what type of exercise do you do, and how many days per week? ____________________
Prescription drug allergies?______________________________

Past surgeries?______________________________
Current Supplements & medications?
____
____
____
____
____
____

Are you a smoker or a former smoker?____
Do you drink alcohol? (Circle) YES or NO
If so, how often and what do you drink? ____
Caffeine?______________________ Marital Status?_____________________
Children?______________________ Occupation?_______________________

Religion/ Ethnicity:____
Do you have a history of toxic exposure? (circle) YES or NO
If yes, what have you been exposed too?____
What is your current stress level with 1 being the best, and 10 being the worst?_______________

Do you have any significant life events happening that causes your stress to go up?
____
____

How is your diet? What do you eat on a daily basis? Organic? Vegan? Low- fat? Pseudo -vegan?
____
____

Authorization: I authorize Sears Institute for Anti-Aging Medicine to release any information including the diagnoses and treatment rendered to me or my dependent to my insurance company. I authorize and request my insurance company to pay directly to the doctor any benefits otherwise payable to me. I acknowledge that I have been offered/received a copy of the privacy practice notice.

X____ Date: ________________________________
(Signature of patient or guardian if minor)

Communication Authorization

The following person/persons listed are hereby authorized to obtain any & all pertinent information via telephone communication with the staff of Dr. Al Sears, MD/Sandra McKenzie, PA.

Name:____

Relationship:____

Contact Phone Number:____

Name:____

Relationship:____

Contact Phone Number:____

Name:____

Relationship:____

Contact Phone Number:____

Name:____

Relationship:____

Contact Phone Number:____

Name:____

Relationship:____

Contact Phone Number:____

Patient Signature:_________________________________

Print Patient Name:________________________________

Date:____

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