WEBSTER FAMILY PHYSICIANS, P.C.

NAME: ____
LAST NAME FIRST MIDDLE

ADDRESS: ____
STREET CITY STATE ZIP

TELEPHONE: Home ____________________ Work ____________________

SOCIAL SECURITY NUMBER: ____________________

DATE OF BIRTH: ____________ MARITAL STATUS: ____________ SEX: ____________

INSURANCE INFORMATION:

INSURANCE COMPANY'S NAME: ____________________

WHAT IS THE PATIENT'S RELATIONSIIIP TO THE INSURED?____________________

INSURED'S NUMBER: ____________________ GROUP NUMBER: ____________________

GROUP NAME: ____________________

MEDICARE #: ____________________ REFERRED BY: ____________________

EMPLOYER: ____________________ STATUS: Full-time ___________Part-time___________

ADDRESS: ____
STREET CITY STATE ZIP

OCCUPATION: ____________________

PERSON RESPONSIBLE FOR BILL IF OTHER THAN PATIENT:

NAME: ____________________ REI.A TIONSIIIP: ____________________

ADDRESS: ____________________ HOME TELEPHONE: ____________________

EMPLOYER: ____________________ WORK TELEPHONE: ____________________

SS #:____________________ DATE OF BIRTH: ____________________

IN CASE OF EMERGENCY, PLEASE NOTIFY: ____________________

NAME: ____________________

ADDRESS: ____________________

TELEPHONE: ____________________ RELATIONSHIP: ____________________

PAYMENT IS DUE AT THE TIME OF SERVICE:

MASTERCARD ____________ VISA ____________ CASH ____________ CHECK ____________

WEBSTER FAMILY PHYSICIANS, P.C.

NAME:____ **AGE:**_____________ **DATE OF BIRTH:**____________________

ADDRESS:____
Street **City** **State** **ZIP**

HOME PHONE: ( )______________________________ **WORK PHONE: ( )**___________________________________

MARITAL STATUS: S M D W Sep NUMBER OF CHILDREN:_______ **REFERRED BY:**________________________

OCCUPATION:______________________________________ **EMPLOYER:**_______________________________________

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE FOR YOU:

COMPLAINT	SINCE	CAUSES

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	SINCE	ADVERSE EFFECTS

WHAT OTHER TREATMENTS OR REGIMES ARE YOU CURRENTLY FOLLOWING?

TREATMENT or REGIME	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

Abscesses		Depression		Heart Disease		Mononucleosis		Rheumatic Fever		Syphilis	
Alcoholism		Diabetes		Hepatitis		Mumps		Rubella		Tonsillitis	
Allergies		Emphysema		Herpes		Parasites		Scarlet Fever		Tuberculosis	
Anemia		Epilepsy		Influenza		Pelvic Inflammatory Disease		Sexual Abuse		Typhoid Fever	
Arthritis		Gall Stones		Kidney Disease				Skin Disease		Venereal Warts	
Asthma		Goiter		Leukemia		Peritonitis		Strep Throat		Warts	
Cancer		Gonorrhea		Malaria		Pleurisy		Sinusitis		Whooping Cough	
Chicken Pox		Gout		Measles		Pneumonia		Sunstroke		Worms	
Cold Sores		Hay Fever		Miscarriage		Prostatitis		Stroke		Yellow Fever	

ANY OTHER MAJOR CONDITIONS?____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL AGAIN, OR WHICH HAVE BEEN MORE SEVERE THAN USUAL? WHICH ONES?______________________________

WHAT OPERATIONS HAVE YOU HAD?

OPERATION	WHEN	COMPLICATIONS

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECTS

Age of First Menses:________________________ Number of Pregnancies:________________

What vaccinations have you had?____

Any adverse effects from them?____

Have you ever taken antibiotics for a prolonged period of time? ____________When?________________

For what condition?____

Have you lost any weight lately? How many pounds?____

What exercise do you do and how much?____

HOW MUCH OF THE FOLLOWING SUBSTANCES ARE YOU USING?

Tobacco:		Alcohol:
Coffee:	Tea:	'Recreational' drugs:

INDICATE BELOW, WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER MAJOR AILMENTS, HAVE AFFECTED YOUR RELATIVES:

Alcoholism Allergies Arthritis	Asthma Cancer Depression	Diabetes Epilepsy Gonorrhea	Gout Hay Fever Heart Disease	Insanity Paralysis Pneumonia	Skin Disease Syphilis Tuberculosis

RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles:			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles:			

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

PHYSICIAN	FOR WHAT CONDITIONS?	TREATMENT

HAVE YOU BEEN TREATED WITH HOMEOPATHY BEFORE?

PHYSICIAN	FOR WHAT CONDITIONS?	WHEN?

Webster Family Physicians, P.C.
7979 Big Bend Boulevard
Webster Groves, Missouri 63119

Privacy Practices Acknowledgement

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received the Notice of Privacy Practices and I have been provided opportunity to review it.

Name ________________________________ **DOB** ________________

Signature ____

Date ____