Medical Information

First Name	Middle Name	Last Name	Suffix	DOB (mm/dd/yyyy)

Current Physical Address	Apt. Number	City	State	Zip Code

Phone	DL/ID Number	DL/ID State	DL/ID Expiration Date

Email Address	Social Security Number	Medicaid, Medicare ,SoonerCare?
		☐ YES ☐ NO

Gender: ☐ Male ☐ Female

If female, are you pregnant? ☐ No ☐ Yes ☐ Unsure

Allergies? ☐ No ☐ Yes

List allergies:

Major Surgeries? ☐ No ☐ Yes

List surgeries:

Dependency on Prescription Meds? ☐ No ☐ Yes

Tobacco Use? ☐ No ☐ Yes

Type:

Amount:

Alcohol Use? ☐ No ☐ Yes

Type:

Amount:

Recreational Drug Use? ☐ No ☐ Yes

Type:

Amount:

How did you hear about us?