DAVID C. REDD, M.D.,P.C.

PLEASE PRINT **DATE _____ / _____ / _____**

Name: First:_____ _____MI: _____ Last: _____

DOB _____/_____/_____ AGE _____ SS# _____-_____-_____

PATIENT ADDRESS_____

CITY _____ STATE _____ ZIP _____ ☐ MALE ☐ FEMALE

HOME # (_____) _____-_____ CELL # (_____)_____-_____

WORK # (_____) _____-_____ Please circle: MARRIED / SINGLE / DIVORCE / WIDOWED

PATIENT EMPLOYER _____ WORK #_____

CITY _____ STATE _____ ZIP _____

SPOUSE/ PARENT: _____ PH:_____

***EMERGENCY CONTACT*: _ _____PH: _____**

Primary Care Physician :_____ PH:#_____

Referring Physician: _____ PH:#_____

PRIMARY INSURANCE _____ INSURED'S NAME _____

DOB _____ GROUP # _____ ID# _____

INSURED'S RELATIONSHIP TO PATIENT _____ EMPLOYER _____

SECONDARY INSURANCE _____ INSURED'S NAME _____

DOB _____ GROUP# _____ ID# _____

INSURED'S RELATIONSHIP TO PATIENT _____ EMPLOYER _____

ASSIGNMENT AND RELEASE

I authorize the payment of medical benefits to David C. Redd, M.D., P.C. for services rendered to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize

the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. This office also has my permission to release my medical records to another medical facility if the occasion should arise.

SIGNATURE _____ DATE _____

MEDICARE ASSIGNMENT AND RELEASE

I request that payment of authorized Medicare benefits be made on my behalf to David C. Redd, M.D., P.C. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine theses benefits or the benefits payable for related services.

SIGNATURE _____ DATE _____

David C. Redd, M.D.

Name _____ Date _____

Answer the following questions about your Health History:

1. How did you hear of Dr. Redd? _____

2. Have you taken Prednisone or steroid medication in the last 3 months? ☐ Yes ☐ No

3. Are you taking a "blood thinner"? ☐ Plavix ☐ Coumadin ☐ Aspirin ☐ No

4. Are you taking? ☐ Herbs ☐ Vitamins ☐ Fish Oil ☐ None

5. Which best describes your nutritional status:
   ☐ I eat 2-4 servings of fruits and vegetables every day
   ☐ I eat fast food more than 2 x per week

6. Are you currently under Pain Management Care? ☐ Yes ☐ No

7. Do you drink alcohol? ☐Yes ☐No ☐ Occasionally ☐ Frequently ☐ Daily
   (1 -2 x / month) (1-2 x/ week)

8. Do you use marijuana or other drugs? ☐ Yes ☐ No

9. Do you smoke? ☐ Yes ☐ No _____Packs/day. How many years? _____

10. Do you use other forms of tobacco? ☐ Yes ☐ No ☐ Smokeless Tobacco?

11. Do you or anyone in your family have a bleeding or clotting disorder? ☐ Yes ☐ No

12. Do you or anyone in your family have problems with gen. anesthesia? ☐Yes ☐ No

13. Do you or anyone in your family have cancer or a history of cancer? ☐ Yes ☐ No

14. Do you have or have you had any problems with the following?

☐ Heart problems	☐ Liver Disease/hepatitis	☐ Depression
☐ Lung Problems	☐ Kidney problems	☐ High B. P.
☐ Stroke	☐Thyroid problems	☐ Seizures
☐ HIV/Aids	☐ Diabetes	☐ Other
☐ Cancer	☐ Blood Clots	

David C. Redd, M.D.

Name: _____

Previous Operations / Procedures

1._____

2. _____

3._____

4. _____

5. _____

6. _____

7. _____

Allergies: _____

Medication	**Dosage**
1._____	
2. _____	
3. _____	
4. _____	

5. _____

6._____

7. _____

8. _____

9. _____

10. _____