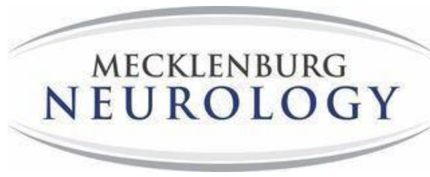


Patient First _________________Middle Name: _______________ Last Name: ____________________ Suffix: _________

DOB: _____________ Age: _____ Reason for visit: __________________________________ How Long? _________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ____________________ Ext: _____

Ok to receive text: ☐ Email: ________________________________ Alternate Email: ________________________________

Preferred Communication: ☐ Home ☐ Work ☐ Cell ☐ Mail ☐ Email ☐ Text Message ☐ Declined

Reminder Language: _________________ Do you give MNG Permission to view your Medication History ☐Yes ☐ No

SSN#______________________ Sex ______ Gender Identity __________ Ethnicity_____________________

Preferred Language________________ Student Status ___________________

Street Address ____

City _____________________ State ________ Zip Code __________

Mailing Address (If different than above) ____

City _____________________ State ________ Zip Code __________

Marital Status _____________

Emergency Contact ___________________________ Phone _____________________ Relationship ________________

Continued Care Information

Referring Provider Name ____________________________ Referring Provider Specialty ________________________

Referring Provider Street Address ____

City _____________________ State ________ Zip Code __________ Phone ______________ Fax _______________

Primary Provider Name ____________________________ Primary Provider Phone ____________________________

Employer Information

Employer ____

Street Address ____

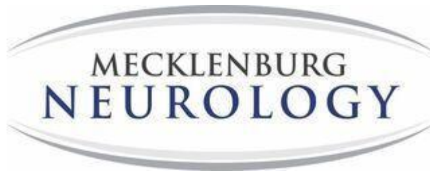
City _____________________ State ________ Zip Code __________ Phone ______________ Fax _______________

Pharmacy

Pharmacy Name ______________________________________

Street Address ____

City _____________________ State ________ Zip Code __________ Phone ______________ Fax _______________



Insurance Information

Primary Insurance

☐ **Subscriber is the patient**

Insurance Company _________________________ ID# _______________ Ins Group Name ____________________

Ins Group # ____________________ Ins Plan Name ____________________ Ins Plan Type ____________________

Ins Phone Number____________________

Secondary Insurance

☐ **Subscriber is the patient**

Insurance Company _________________________ ID# _______________ Ins Group Name ____________________

Ins Group # ____________________ Ins Plan Name ____________________ Ins Plan Type ____________________

Ins Phone Number____________________

Tertiary Insurance

☐ **Subscriber is the patient**

Insurance Company _________________________ ID# _______________ Ins Group Name ____________________

Ins Group # ____________________ Ins Plan Name ____________________ Ins Plan Type ____________________

Ins Phone Number_____________________

Guarantor Information

First Name __________________ Middle Name: ________________ Last Name: _____________________

DOB: ______________ Relationship ______________________ Phone _________________

Email: _________________________________

Street Address ____

City ______________________ State ________ Zip Code __________

Past Imaging

(Please list dates and results)

MRI: ____

CT: ____

Mammogram: ____

Nuclear Medicine: ____

Xray: ____

PET Scan: ____

Ultrasound: ____

MRA: ____

Any other past Testing? ____

Developmental

Right or Left-Handed: _______________ Are you disabled? ☐ Yes ☐ No Do you do heavy lifting? ☐ Yes ☐ No

Habits

Do you or have you smoked Cigarettes or Cigars? ☐ Yes ☐ No When did you stop? ______ Packs per day___

Do you drink alcohol? ☐ Yes ☐ No When did you stop? _________ Drinks per week ________

Do you use Recreational drugs? ☐ Yes ☐ No When did you stop? _________ Name of Drug ____________

Do you drink caffeinated beverages? ☐ Yes ☐ No Drinks per day ________

Past Medical History

(Please mark all that apply)

☐ Myocardial Infarction
☐ Congestive Heart Failure
☐ Angina or Chest Pain
☐ Diabetes Mellitus
☐ Hypertension
☐ Hypercholesterolemia
☐ Cerebrovascular Accident
☐ Transient Ischemic Attack
☐ Cancer
☐ Asthma
☐ COPD
☐ Peptic Ulcer Disease
☐ Thyroid
☐ Arthritis
☐ Psychiatric
☐ Depression
☐ AIDS
☐ TB
☐ Atrial Fibrillation
☐ Uncontrollable Crying
☐ none

Notes:____
____

Past Surgical History

☐ Angioplasty
☐ Appendectomy
☐ Adenoidectomy
☐ Tonsillectomy
☐ Coronary Artery Bypass Graft
☐ Heart Valve Repair
☐ Cataract Surgery
☐ Cholecystectomy
☐ Colonoscopy
☐ Congenital adrenal hyperplasia
☐ Thyroidectomy
☐ Breast Biopsy
☐ Partial Mastectomy
☐ Full Mastectomy
☐ Laparotomy
☐ Hemorrhoidectomy
☐ Intestinal Surgery
☐ Hernia Repair
☐ D&C
☐ Bilateral Tubal Ligation
☐ Cesarean section
☐ GU TURP
☐ Orthopedic
☐ Hip Replacement Surgery
☐ Below the knee amputation
☐ Septoplasty
☐ Rhinoplasty
☐ Tympanostomy
☐ Back
☐ Vasectomy
☐ Weight Loss Surgery
☐ Malignant Hyperthermia

Notes:____
____

Childhood Illnesses

☐ Chickenpox
☐ Whooping Cough
☐ Pneumonia
☐ Tetanus
☐ Measles
☐ Scarlet Fever
☐ RSV
☐ Rheumatic Fever
☐ CMV
☐ Epstein-Barr Virus
☐ Cancer

Notes:____
____

Last Well Check with Primary Care Provider: ____________

Family History

Please indicate who in family has had illness

Epilepsy: ____ High Cholesterol: ____

Alcoholism: ______________________________________ Migraines: ____

Heart Disease: ____________________________________ Stroke: ____

Diabetes: ____ High Blood Pressure: ____________________________________

Genetic Disease: __________________________________**name of Genetic disease**: __________________________________

Cancer: ____**type of Cancer**: ____

Mental Illness: ____________________________________**name of mental illness**: ___________________________________

Social History

Where is patient from: ____

Education Status: ___________________________ Student Where: ____

Who does patient live with: ____

Medications

Please list name of medication and dose

____

____

____

____

Drug Allergies

____

____

____

____