Confidential Patient Information					
Patient Name:				Date:	
Address:				Apt:	
City, State				Zip:	
Email*:					
*By providing your email address you are agreeing to communication via email.					
Home Phone *Primary contact* ☐		Work Phone *Primary contact* ☐		Cell Phone *Primary contact* ☐	
Date of Birth:		Age:		Sex:	Male Female
Employer:		Address:			
Whom may we contact in case of EMERGENCY?					
Name:				Phone:	

How did you hear about us? (Please circle one)

Facebook Google Bing Yahoo Other Internet Search_____ TV/Infomercial Magazine

Radio (Station?)_____ Billboards Current Patient _____ Other _____

Consent to Treat

I, the undersigned, hereby voluntarily consent and grant permission to J Bergeron MD PA, physician and employees to perform tests, treatment and any procedures as indicated at J Bergeron MD PA for myself or the above named minor, for as long as I am a patient at J Bergeron MD PA.

Signature of Patient or Personal Representative _____ Date _____

Consent to Photographs

I consent to photographs being taken for medical and diagnostic purposes. I understand these photos will not be used for any advertising and/or marketing purposes without my further written consent.

Signature of Patient or Personal Representative _____ Date _____

Occupational Hazard

In the event of an injury (i.e. needle stick) to an employee, that exposes any of my bodily fluids, at J Bergeron MD PA premises, I the undersigned, hereby voluntarily consent to give a blood specimen for testing.

Signature of Patient or Personal Representative _____ Date _____

Acknowledgement of Review of HIPAA/Notice of Privacy Practices and Patient Rights

I have reviewed this office's HIPAA/Notice of Privacy Practices and Patient Rights. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative _____ Date _____

Name:		**DOB:**	**Today's Date:**
SYMPTOMS: Please circle any of the following symptoms that you **have now or have had recently.**			
Nervousness / Anxiety	Sweats	Excessive thirst	Blurred vision
Headache	Loss of weight	Hemorrhoids	Double vision
Depression	Appetite poor	Indigestion	Earache
Dizziness	Bowel changes	Nausea	Loss of hearing
Fainting	Constipation	Stomach pain	Nosebleeds
Fever	Diarrhea	Vomiting	Ringing in ears
Forgetfulness	Difficulty swallowing	Ringing in ears	Sinus problems
Loss of sleep	Excessive hunger	Bleeding gums	Change in moles
Chest pain	Bruise easily	Wheezing	Rash
Irregular heart beat	Hives	Persistent cough	Sore that won't heal
Swelling of ankles	Itching	Coughing blood	Painful urination
Shortness of breath	Wheezing	Blod in urine	
Lack of bladder control	Frequent urination	Poor uninary stream	
Pain, weakness &/or numbness in the following:			
Arms	Hands	Feet	Neck
Back	Feet	Legs	Shoulders
Men Only:			
Breast Lump	Lump in Testicles	Erection Difficulties	Other: _____
Women Only:			
Last Mentral Period?	_____	Date of Last Pap Smear?	_____
Date of Last Mamogram?	_____	Are you Pregnant?_____	# of Children _____
DIAGNOSES: Please circle if you have been diagnosed or treated for any of the following.			
AIDS	Chemical dependency	High cholesterol	Psychiatric disorders
Alcoholism	Chicken pox	High Blood Pressure	Rheumatic fever
Anemia	Diabetes mellitus	HIV positive	Scarlet fever
Anorexia	Emphysema	Kidney disease	Stroke
Arthritis	Epilepsy / Seizures	Measles	Suicide attempt
Asthma	Glaucoma	Migraine headaches	Thyroid problems
Bleeding disorders	Goiter	Mononucleosis	Tonsillitis
Breast lump	Gonorrhea	Multiple sclerosis	Tuberculosis
Bronchitis	Gout	Mumps	Typhoid fever
Bulimia	Heart disease	Pacemaker	Ulcers – if yes, type
Cataracts	Hepatitis	Pneumonia	Vaginal infection
Prostate problem	Polio	Varicose veins	Venereal disease
Cancer Type:_____		Herpes Type: _____	Hernia: Type:_____

HOSPITALIZATIONS or SURGERIES			PREGNANCY HISTORY		
Date	**Hospital**	**Reason for hospitalization/surgery**	**Year of**	**Boy or Girl**	**Outcomes / Type of Delivery**

Have you ever had a blood transfusion? Yes No **If yes, please give approximate dates:**

HEALTH HABITS Check (√) which substances you use and describe how much use			OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following	
	Caffeine			Stress
	Tobacco	(packs/day)		Hazardous substances
	Drugs			Heavy lifting
	Alcohol	(drinks/week)		Contact with blood or body fluids
	Other			Other

FAMILY HISTORY: Fill in health information about your family.

Relation	Age	Health	Death	Cause of Death		Disease	Relationship to you
Father						Obesity	
Mother						Asthma, Hay fever	
Brothers						Cancer and type	
						Chemical dependency	
						Diabetes	
						Heart disease, Strokes	
Sisters						High blood pressure	
						Elevated cholesterol	
						other	

WEIGHT HISTORY: (Diet Patients Only)

Weight Loss Programs	Lowest Weight/Age		Highest Weight/Age		RESULTS COMMENTS
None					
Jenny Craig					
Weight Watchers					
Medical Weight					
Atkins					
Other					

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:		Date:	
Reviewed By:		Date:	

Name:		**Date of Birth:**		**Todays Date:**	
Pharmacy:		**Pharmacy Phone:**			
MEDICATIONS:	Dose	Number of Pills	How Often	For What	Discontinued Date
Example: *Calcium*	500 mg	1	2 times a day	Bones	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

ALLERGIES: Medications or substances	Symptoms/Reactions
☐ No Known Allergies	
1.	
2.	
3.	
4.	

Changes since your last visit? If no, please initial and date below. If yes, please indicate above.
Date/Initial
Date/Initial
Date/Initial
Date/Initial
Date/Initial
Date/Initial
Date/Initial
Date/Initial
Date/Initial