

Kenmore

**Dr. James Burruano**

East Aurora

<b>PATIENT INFORMATION FOR MEDICAL RECORDS (Please Print)</b>						<b>Date:</b>
<input type="checkbox"/>	MR.	LAST NAME	FIRST NAME	MIDDLE		
<input type="checkbox"/>	MRS.					
<input type="checkbox"/>	Ms.					
<b>PATIENT ADDRESS</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>HOMEPHONE</b>	
→						
<b>SOCIAL SECURITY NUMBER</b>			<b>DATE OF BIRTH</b>	<b>AGE</b>	<b>MARITAL STATUS</b>	
→					M S D W SEP.	
<b>PATIENT EMPLOYER OR SCHOOL</b>					<b>OCCUPATION</b>	
→						
<b>EMPLOYER'S ADDRESS</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>BUS. PHONE</b>	
→						
<b>SPOUSE'S NAME</b>			<b>FAMILY PHYSICIAN</b>			
→						
<b>SPOUSE'S EMPLOYER</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>BUS. PHONE</b>	
<b>IN CASE OF EMERGENCY CONTACT:</b>	<b>NAME</b>	<b>ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>TELEPHONE</b>
<b>MEDICAL INSURANCE INFORMATION - Please Provide Your Cards.</b>						
<b>IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, PLEASE COMPLETE THIS SECTION</b>						
<b>Responsible Party</b>	MR.	LAST NAME	FIRSTNAME	MIDDLE		
	MRS.					
	MS.					
<b>ADDRESS</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>TELEPHONE</b>	
→						
<b>OCCUPATION</b>	<b>EMPLOYED BY</b>					
→						
<b>EMPLOYER'S ADDRESS</b>	<b>STREET</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>	<b>BUS. PHONE</b>	
→						

I hereby authorize Dr. James Burruano to release any and all medical information to the above-named insurance carrier (or to a designated attorney) for purposes of claims administration and evaluation, utilization review, and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Dr. James Burruano all money which I am entitled for medical and/or surgical expense relative to the service rendered by it, but not to exceed my indebtedness to said physician and/or clinic. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court costs and reasonable legal fees should this be required.

Insured or  
Guardian's Signature \_\_\_\_\_

Patient's  
Signature \_\_\_\_\_

PLEASE TURN OVER

Name \_\_\_\_\_

## PATIENT'S PERSONAL HISTORY

	Yes	No		Yes	No
<b>Do you have allergies?</b>	<input type="checkbox"/>	<input type="checkbox"/>			
What is reaction _____			<b>Are you using harmful drugs</b>	<input type="checkbox"/>	<input type="checkbox"/>
Name of medication _____			<b>Do you use alcohol regularly</b>	<input type="checkbox"/>	<input type="checkbox"/>
			How often _____		
			How much _____		
<b>Are You Taking Medicine Regularly?</b>	<input type="checkbox"/>	<input type="checkbox"/>			
Please list					
_____			<b>Have you ever had:</b>		
_____			Back injury	<input type="checkbox"/>	<input type="checkbox"/>
_____			Back surgery	<input type="checkbox"/>	<input type="checkbox"/>
_____			Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>
			Rheumatism or arthritis	<input type="checkbox"/>	<input type="checkbox"/>
			Fracture of bone	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have You Ever Had:</b>					
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<b>Have you ever had:</b>		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath in walking	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Tightness of chest	<input type="checkbox"/>	<input type="checkbox"/>			
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<b>Do you have:</b>		
Do you smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or sugar in urine	<input type="checkbox"/>	<input type="checkbox"/>
Packs per day _____			Thyroid trouble or goiter	<input type="checkbox"/>	<input type="checkbox"/>
How many years _____			Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever worked in a dusty trade	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Valve Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have You Ever Had:</b>			Blood Thinners	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>			
Heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>			
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Do You Have:</b>					
Stomach ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hobbies _____		
Frequent nausea	<input type="checkbox"/>	<input type="checkbox"/>	Married M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/>		
Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Children _____		
			Drug Abuse _____		
<b>Have You Ever Had:</b>					
Fits or convulsions	<input type="checkbox"/>	<input type="checkbox"/>			
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>			
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>			
Numbness of hands, feet	<input type="checkbox"/>	<input type="checkbox"/>			
Double vision	<input type="checkbox"/>	<input type="checkbox"/>			

**Patient Signature** \_\_\_\_\_