

Name		DOB		Age	
Reason for the visit today					
Primary Care Physician or Referring Physician:					
Allergies to any medications ? <input type="checkbox"/> Yes <input type="checkbox"/> No (List with reaction)		Latex Allergy ? <input type="checkbox"/> Yes <input type="checkbox"/> No			
HEIGHT			WEIGHT		
Medical History – Do you have or have you had any of the following?					
General Health	Yes ✓	Genitourinary	Yes ✓	Other	Yes ✓
Eyes				Family History	
Cataract		Pain with Urination		Breast Cancer	
Glaucoma		Kidney/Bladder Infection		Melanoma	
Visual Disturbance		Kidney Stone		Other Cancer	
Diabetic Retinopathy		Hysterectomy		Bleeding problems	
Ear, Nose & Throat		Breast		Diabetes	
Sinus Drainage		Breast Cancer		Blood Clot Problems	
Hearing Loss		Breast Infections		Arterial Disease	
Respiratory		Nipple Discharge		Stroke	
Asthma		Musculoskeletal		High Blood Pressure	
COPD		Arthritis		Problems with Anesthesia	
Environmental Allergies		Back Pain		Varicose Veins	
Anesthesia Problems		Back Injury		Depression	
Gastrointestinal		Back Surgery		Heart Disease	
Irritable Bowel Disease		Vascular		Other	
Crohn's Disease		Arterial Disease			
Ulcerative Colitis		Venous Disease			
Gall Stones		Varicose Veins			
Hepatitis		Leg Ulcers			
Skin		Endocrine			
Skin Cancer		Diabetes			
Melanoma		Insulin Controlled			
Rosacea		Oral Controlled			
Healing Problems		Diet Controlled			
Cardiac		Thyroid Disease			
High Blood Pressure		Diabetic Nephropathy			
Chest Pain/Angina		Neurologic			
Heart Failure		Stroke			
Irregular Heart Rhythm		Seizure			
Pacemaker		Depression or mental illness			
Cardiac Cath		Auto-immune			
Coumadin/Blood Thinners		Taking Prednisone			
Hematology/Lymph		Lupus			
High Cholesterol		Rheumatoid Arthritis			
Swollen Legs		HIV/AIDS			
Bleeding/Bruising Disorder					
Anemia		Scleroderma			
Blood Clots in Legs					
Pulmonary Embolus					

Welcome to our office

GLENN E. HERRMANN, MD, PC
1032 South 88th Street
Louisville, Colorado 80027

Please print and complete all sections

Today's Date		Patient Account Number	
Patient Name (this section refers to PATIENT ONLY)			
First	Middle Initial	Last	
Address		City	State Zip
Home Phone	Work Phone	Employer	
Date of Birth	Age	Sex	Social Security Number
Spouse	Employer	Work Phone	
Email address			
RESPONSIBLE PARTY (Person who should receive bill)			
Name		Relationship to patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Address		City:	State Zip
Home Phone		Work Phone	
Auto Injury <input type="checkbox"/>	Claim #	Date of Accident	
Work Comp <input type="checkbox"/>	Claim #	Date of Accident	
Other Injury (Specify)		Date of Accident	
REFERRED BY:			
INSURANCE (Please complete thoroughly. We will need a copy of your insurance card and photo ID)			
Primary Insurance		Secondary Insurance	
Address		Address	
City, State, Zip		City, State, Zip	
Phone: Area Code ()		Phone: Area Code ()	
Employer		Employer	
Primary Insured Person		Primary Insured Person	
ID/Policy #		ID/Policy #	
Group #		Group #	
Social Security Number		Social Security Number	
NOTIFY IN CASE OF EMERGENCY (Not living with you)			
Name		Home Phone	
Address		Work Phone	
Please sign by both X's			
I authorize payment of medical benefits to physician or supplier for these services and all future claims.		I authorize the release of any medical information necessary to process this claim and all future claims.	
X		X	
Signed (Insured or Authorized Person)		Signed (Insured or Authorized Person)	
For Office Use Only			
Accept Assignment <input type="checkbox"/> Yes <input type="checkbox"/> No	Accept Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	Deductible <input type="checkbox"/>	