720 Goodlette Rd. N., Ste. 204
Naples, FL 34102
(239) 260-3880

Personal Information	**Date:**

Name: _____

Date of Birth: _____ **Social Security No**: _____ **Marital Status**: _____

Home Address: _____
City **State** **Zip Code**

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail (Home): _____ **Preferred Method of Contact :** _____

Referred by: _____ **Other Doctors:** _____

Primary person to be notified in case of an emergency:

Name: _____

Relationship: **Relative** _____ **Friend** _____ **Other** _____

Home Address: _____
City **State** **Zip Code**

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail Address: _____

Insurance Information:

Insurance Company: _____

Subscriber Name/Date of Birth: _____

Subscriber ID: _____ **Group/Plan Number:** _____

Employer/Group Name: _____

PLEASE BE ADVISED THAT WE ARE UNABLE TO BILL ANY INSURANCE ACCEPTED BY OUR OFFICE WITHOUT A COPY OF THE CURRENT INSURANCE CARD. Also, in the event your insurance company denies the claim for ANY reason, you will be personally responsible for the charges incurred.

Assignment of Benefits: I authorize assignment of all medical insurance benefits to the named provider for the medical services rendered.

Signature: _____ Date: _____

Assignment to pay for Services: I agree to pay AIM Naples for all charges for services rendered to the patient today, or any future date of service in the office. I understand payment in full and/or co-pay and/or co-insurance is expected at the time of services rendered. I further understand, in the event this account is referred to an agency or attorney for collection, I will be responsible for all collection fees, attorneys' fees and/or court costs.

Signature: _____ Date: _____

Please list all doctors you have seen in the last 5 years

Doctor's Name	Address	Phone	Reason for visits

Past Medical History: **please check all that apply**

____ AIDS/HIV (specify): _____

____ ALS

____ Alzheimer's Disease

____ Arthritis/R.A. (specify: _____

____ Asthma

____ Auto-Immune Disorder (specify): _____

____ Back, Neck, Disc Injury/Disease (specify): _____

____ Bladder Issues (urinary incontinence)

____ Blood Disorders (specify): _____

____ Brain Disorders (specify): _____

____ Breast Lesions

____ Cancer (specify): _____

____ Chronic Pain/Fibromyalgia (specify): _____

____ Colitis/IBS/Intestinal Disorders (specify): _____

____ COPD

____ Crohn's Disease

____ Diabetes (Type?): _____

____ Dystonia (spasms/tremors)

____ Eating Disorders (anorexia/bulimia)

____ Endocrine Problems (Thyroid/Hormones)(specify): _____

____ Epilepsy/Seizures (specify): _____

____ GERD/Acid Refulx/Ulcers/Stomach Problems (specify): _____

____ Headaches/Migraines

____ Hearing Loss/Hearing Aids/Tinnitus (specify): _____

____ Heart Disease (specify): _____

____ Hepatitis A, B or C / Liver Disease(specify): _____

____ Kidney Disease

____ Lung Disease (specify): _____

____ Mental Disorders/Bipolar/Depression/PTSD/Schizophrenia (specify): _____

____ Multiple Sclerosis

____ Osteoporosis/Bone Loss

____ Parkinson's Disease

____ Poor Circulation/Swelling/Phlebitis (specify): _____

____ Prostate Disease

____ Sciatica

____ Scoliosis

____ Shortness of Breath

____ Sinus Problems/Allergies (specify): _____

____ Sleep Disorders (Insomnia/Apnea/Snoring)

____ Stroke/TIA

____ Vision Problems (Cataracts/Glaucoma/Macular Degeneration)(specify): _____

____ Weight Loss/Gain – Amount/Reason (specify): _____

Surgical History: ____ Yes ____ None

Please list any surgeries and date of such surgery:

Date of Surgery	Type of Surgery or Condition

Describe non-surgical treatments you have received/are receiving for your medical condition(s):

___ physical therapy ___ injections ___ chiropractic ___ acupuncture ___ pain specialist
___ therapist ___ social worker ___ psychiatrist ___ orthopedist ___ heart specialist
___ nerve specialist ___ oncologist ___ endocrinologist

___ other (specify): _____

Medications: List all medications currently taking:

Medication	Dosage	Times per day	Reason for taking

List any medications to which you are allergic:

Medication	Type of Reaction