DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT INFORMATION SHEET

Please Print - Complete All Information

SOCIAL SECURITY# _____ TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ ❑ MARRIED ❑ SINGLE ❑ WIDOWED ❑ DIVORCED SEX: ❑ MALE ❑ FEMALE

DRIVER'S LICENSE# _____

EMERGENCY CONTACT _____ PHONE _____

REFERRED BY: ❑ DOCTOR _____ ❑ FRIEND ❑ OTHER PATIENT

❑ INSURANCE CO. _____ OTHER _____

ADJUSTER NAME _____ PHONE _____

CLAIM # _____

EMPLOYER _____ ADDRESS _____ PHONE _____

EMPLOYMENT STATUS: ❑ FULL-TIME ❑ PART-TIME ❑ UNEMPLOYED ❑ STUDENT ❑ HOUSEWIFE/HUSBAND

WORKER'S COMPENSATION / PERSONAL INJURY

❑ AUTO ACCIDENT ❑ WORK COMP ACCIDENT ❑ OTHER

DATE OF ACCIDENT _____ WHAT AREAS WERE INJURED? _____

DESCRIPTION OF ACCIDENT _____

WERE YOU TAKEN TO THE HOSPITAL OR RECEIVE TREATMENT FOR THIS INJURY? IF SO, WHERE?

_____

WERE X-RAYS TAKEN? _____ MEDICATION PRESCRIBED? _____

CURRENT COMPLAINTS _____

ANY PRIOR INJURIES? IF YES, GIVE DATES AND DESCRIPTIONS _____

_____

BRIEF MEDICAL HISTORY

❑ HIGH BLOOD PRESSURE
❑ HEART DISEASE
LAST MENSTRUAL PERIOD
_____

❑ DIABETES
❑ ASTHMA
❑ TOBACCO USE
❑ ULCERS

❑ CANCER
❑ KIDNEY DISEASE
❑ ARTHRITIS
❑ SURGERY

❑ OTHER _____
_____

CURRENT MEDICATIONS _____

MEDICATION ALLERGIES _____

PRIMARY CARE PHYSICIAN _____

HEIGHT FT. _____ INCHES _____ WEIGHT _____ LBS