DR. JEFFREY D. GABER
& ASSOCIATES, PA

PATIENT INFORMATION SHEET - PLEASE PRINT - COMPLETE ALL INFORMATION

SOCIAL SECURITY # _____ - _____ - _____ TODAY'S DATE: _____

LAST NAME: _____ SUFFIX: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____) _____ WORK PHONE: (_____) _____ EXT: _____

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

DRIVER'S LICENSE #: _____ EMERGENCY CONTACT: _____ PHONE: (_____) _____

CELL PHONE: (_____) _____ MINORS: MOM'S WORK PHONE (_____) _____
DAD'S WORK PHONE: (_____) _____

PHARMACY: _____ ADDRESS: _____ PHONE: (_____) _____

CURRENT EMPLOYER: _____ EMPLOYER AT TIME OF INJURY: _____

EMPLOYMENT STATUS: _____ FULL TIME _____ PART TIME _____ UNEMPLOYED _____ STUDENT _____ HOUSEWIFE/HUSBAND

NAME OF ATTORNEY _____

INSURANCE COMPANY _____

WORKER'S COMPENSATION / PERSONAL INJURY: ❑ Auto Accident ❑ Work Comp Accident

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 DESCRIPTION: _____

TOBACCO HISTORY NO _____ YES _____ #PACKS PER DAY _____ #YEARS SMOKED _____ QUIT? _____ WHEN? _____

BRIEF MEDICAL HISTORY

HIGH BLOOD PRESSURE _____ DIABETES _____ ULCERS _____ ARTHRITIS _____

HEART DISEASE _____ ASTHMA _____ CANCER _____ SURGERY _____

LAST MENSTRUAL PERIOD _____ BLEEDING _____ KIDNEY DISEASE_____ OTHER _____

CURRENT MEDICATIONS: _____

MEDICATION ALLERGIES: _____

PRIMARY CARE PHYSICIAN: _____ HAVE YOU BEEN A PATIENT OF THIS PRACTICE PREVIOUSLY? _____

HEIGHT _____ FT _____ INCHES WEIGHT _____ LBS