Dr. Edwin Su

New Patient Form

First Name | M.I. | Last Name | Suffix

Social Security Number | Date of Birth

Address: _____

_____

City: _____

State: _____ Zip: _____

Home Number: _____ - _____ - _____

Work Number: _____ - _____ - _____

E-mail: _____

Occupation: _____

Employer: _____

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's Name: _____

Phone: _____ - _____ - _____

Emergency Contact (other than spouse): _____

Phone: _____ - _____ - _____

Referring Physician: _____

Work Number: _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Ethnicity (Check all that apply):

☐ White/Caucasian (not Latino/Hispanic)
☐ Asian/Oriental/Pacific Islander
☐ Black/African American
☐ American Indian/Native Alaskan
☐ Latino/Hispanic/Mexican American
☐ Other (Specify): _____

Primary Insurance Information:

Primary Insurance: _____

Insured Name: _____

Type of Insurance:

☐ PPO
☐ HMO
☐ Medicaid
☐ Medicare
☐ Medicare Supplement
☐ Fee-for-Service/Private
☐ Veteran's Affairs/Other Military
☐ FEHB Program (Federal)
☐ No Insurance/Self-Pay
☐ No Insurance/Charity

Secondary Insurance Information:

Secondary Insurance: _____

Insured Name: _____

Type of Insurance:

☐ PPO
☐ HMO
☐ Medicaid
☐ Medicare
☐ Medicare Supplement
☐ Fee-for-Service/Private
☐ Veteran's Affairs/Other Military
☐ FEHB Program (Federal)
☐ No Insurance/Self-Pay
☐ No Insurance/Charity

Assignment: I certify that the information given by me is correct. I hereby authorize the release of information related to my medical care as requested by government agencies and/or insurance carriers. I understand that the doctor I am seeing does not participate in any HMO Plans, and that I am responsible for any deductible, co-payment, and balance after my claim(s) has/have been processed. I hereby assign benefits to my physician and understand that in the absence of insurance coverage I am responsible for full payment for services rendered.

Signature: _____ Date: _____ / _____ / _____

HSS

Edwin Su, M.D.

Medical Profile

Current Medications (Please include ***prescription drugs*** and drugs you buy ***over the counter***)

Medications:	Reason for taking:	Dose:	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			

Past Medical History

Please list allergies: Reaction:

1. _____ _____
2. _____ _____
3. _____ _____

Review of Systems:

Are you currently having or have had any problems with:

- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Palpitations
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ COPD
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Productive Sputum
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Ulcers
- ☐ Thyroid
- ☐ IBS
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Hepatitis/Liver Disease
- ☐ HIV
- ☐ Urinary Problems
- ☐ Lupus
- ☐ Cancer
- ☐ Seizures
- ☐ Gout
- ☐ Anxiety
- ☐ Depression
- ☐ Weight Loss
- ☐ Anemia
- ☐ Varicose Veins
- ☐ Tuberculosis
- ☐ Eyes
- ☐ Ears, Nose, Throat
- ☐ Bleeding Tendency
- ☐ Other 1. _____
  2. _____

Previous Illnesses:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Previous Operations:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you smoke? ☐ Yes ☐ No

If yes, number of packs per day? ☐☐ Number of years? ☐☐

Do you drink? ☐ Yes ☐ No

If yes, number of drinks per week? ☐☐ Number of years? ☐☐