

CARY INTERNAL MEDICINE & THE DIABETES CENTER

103 BAINES CT SUITE 200 CARY, NC 27511 919-467-6125

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ DATE OF BIRTH _____

ADDRESS _____ APT _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ - _____ - _____ SEX _____ M _____ F MARITAL STATUS _____

PHONE: HOME _____ CELL _____ WORK _____

E-MAIL _____ DRIVERS LICENSE # _____ STATE _____

EMPLOYED BY _____ PHONE _____

RACE (OPTIONAL) _____ PREFERRED LANGUAGE _____

HAS A FAMILY MEMBER BEEN SEEN HERE BEFORE? _____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED? _____

RELATIONSHIP TO PATIENT _____ PHONE _____

PRIMARY INSURANCE

INSURANCE COMPANY _____ ID # _____ GROUP # _____

PERSON RESPONSIBLE FOR ACCOUNT _____ BIRTH DATE _____

ADDITIONAL INSURANCE

INSURANCE COMPANY _____ ID # _____ GROUP # _____

PERSON RESPONSIBLE FOR ACCOUNT _____ BIRTH DATE _____

ALLERGIES? _____

I authorize my insurance company, attorney, or other party to pay directly to Cary Internal Medicine & The Diabetes Center any medical expenses related to my care, unless otherwise stated. I accept responsibility for payment for any medical expenses incurred regardless of insurance coverage.

Patient or Guardian Signature _____ Date _____

LIST OF CURRENT MEDICAL PROBLEMS OR RECURRING MEDICAL PROBLEMS:

DATE OF PREVIOUS HOSPITAL ADMISSIONS, SURGERIES OR SERIOUS ILLNESSES:

Date of last physical exam? _____ Date of last PAP smear? _____

FAMILY HISTORY:

AGE/CURRENT HEALTH

SERIOUS ILLNESSES

CAUSE OF DEATH/AGE

MOTHER:

FATHER:

BROTHERS:

SISTERS:

OTHERS:

LIFESTYLE INFORMATION

Occupation _____ Tobacco _____

Alcohol _____ Caffeine _____

Physical exercise (type/frequency) _____
