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)_____

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