JOSEPH J. FATA, M.D.,
OFFICE INFORMATION

Last Name: _____ First Name: _____ M.I: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Ph. #: _____Work Ph. #: _____ Ext: _____

Employer: _____ School: _____

e-mail Address: _____

Marital Status: S M D W Cell Phone #: _____ Sex: M F

Social Security #: _____ Birth Date: _____ Primary Insurance: _____

Person Responsible for Bill (Guarantor): Self Spouse Parent Other

Last Name: _____ First Name: _____ M.I. _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Ph. #: _____Work Ph. #: _____ Employer: _____

e-mail: _____ Martial Status: S M D W

Cell Phone #: _____ Birth Date: _____ Sex: M F

Social Security#: _____ Referred by: _____

Primary Insurance: **(**TO PROPERLY FILE INSURANCE, THIS MUST BE COMPETED IN FULL**)

Relationship of Policy Holder to Patient: Self Spouse Child Other

Insurance Company: _____ Group #: _____ Insured ID #: _____

Insurance Address: _____City: _____ State: _____ Zip: _____

Secondary Insurance:

Relationship of Secondary Policy Holder to Patient: Self Spouse Child Other

Policyholder Last Name: _____First Name: _____M.I.: _____

Home Address: _____ City: _____ State: _____ Zip_____

Home Ph. #: _____Work Ph. #: _____ Employer: _____

e-mail: _____ Martial Status: S M D W

Cell Phone #: _____ Birth Date: _____ Sex: M F Social Security#: _____

Insurance Company: _____Group #: _____ Insured ID #_____

Insurance Co. Address: _____City: _____State: ____ Zip: _____

JOSEPH J. FATA, M.D.
MEDICAL HISTORY

Last Name: _____ First: _____ Middle: _____

Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge.

How were you referred to our office? Friend or Family _____ Doctor _____

Internet (Please identify any referrals from a specific website) _____

Indianapolis Monthly Ad _____ Yellow Page Ad _____ Open House Invitation _____ Other _____

What is the reason for your visit? _____

List Drug Allergies: _____

Current medications with doses (including non-prescription drugs such as aspirin): _____

_____

Do you or have you ever had: (Circle and give date of onset)

Heart Disease	No	Yes	_____	Psychiatric illness	No	Yes	_____
Heart Attack	No	Yes	_____	Neurologic disease	No	Yes	_____
Lung disease	No	Yes	_____	Bleeding tendency	No	Yes	_____
Asthma	No	Yes	_____	Bruising tendency	No	Yes	_____
High blood pressure	No	Yes	_____	Radiation therapy	No	Yes	_____
Stroke	No	Yes	_____	Rheumatic fever	No	Yes	_____
Diabetes	No	Yes	_____	Ulcers	No	Yes	_____
Hepatitis	No	Yes	_____	Cancer	No	Yes	_____
Kidney disease	No	Yes	_____	Breast disease	No	Yes	_____
Thyroid disease	No	Yes	_____	Depression	No	Yes	_____
Tuberculosis	No	Yes	_____	Slow healing	No	Yes	_____

Do you smoke? No ____ Yes ____ How much? _____
Do you drink alcohol/beer? No ____ Yes ____ How much? _____
Are you at risk for HIV (AIDS)? No ____ Yes ____

Previous surgery (include dates): _____

_____

_____

Family History of Illnesses: _____

Do you know of a blood relative who has had a bleeding disorder or an adverse reaction to anesthesia?

No ____ Yes ____ (If yes, give details)_____

_____

EMERGENCYCONTACT: _____
Name Relation Daytime Phone #