Joseph S. Grasso, DO

Family Practice of Traditional Osteopathic Medicine

PATIENT NAME ______ SEX MALE FEMALE

ADDRESS ______ D.O.B ______ AGE ______

CITY ______ HOME PHONE ______

STATE ______ ZIP CODE ______ WORK PHONE ______

MARITAL STATUS ______ CELL PHONE ______

REFERRED BY ______ SS# ______

EMAIL ADDRESS ______

PERSON RESPONSIBLE FOR BILL ______

EMPLOYER ______

PURPOSE FOR VISIT ______

SURGERIES ______ DATE ______

______ DATE ______

ACCIDENTS ______ DATE ______

______ DATE ______

HOSPITALIZATIONS ______ DATE ______

______ DATE ______

ALLERGIES (environmental, drugs, food)

______

______

DID YOU SMOKE? ______ HOW MUCH? ______

DO YOU DRINK? ______ HOW MUCH? ______

I AUTHORIZE TREATMENT FOR MYSELF AND/OR DEPENDENTS BY MY SIGNATURE BELOW. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL AT EACH APPOINTMENT. THIS OFFICE RESERVES THE RIGHT TO CHARGE FOR MISSED APPOINTMENTS IF WE ARE NOT NOTIFIED WITHIN 24 HOURS OF THE SCHEDULED APPOINTMENT. THIS OFFICE DOES NOT ACCEPT ANY MEDICAL INSURANCE INCLUDING MEDICARE. WE ARE NOT A MEDICARE PROVIDER.

SIGNATURE: ______ DATE: ______

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