Office of Dr. Michael N. Rutman, D.O., AMC

2355 So. Melrose Dr., Vista, CA 92081

Patient Information

Name: _____ SS# _____-_____-_____
Last/First **Middle Initial**

Marital Status: Single Married Widowed Separated Divorced

Sex: Male / Female Referred by: _____

Date Of Birth:_____ Age:_____ Driver's License#_____

Street Address_____ City_____ State_____ Zip_____

Email: _____

Phone: (__)_____ (__)_____ (__)_____
Home **Cell** **Work**

Occupation:_____ Employer_____

Employer Address:_____ City:_____ State: _____ Zip:_____

Work Phone:_____

Spouses Name: _____ _____ DOB: _____
Last/First **/** **Middle Initial** **MM/DD/YY**

Spouses Phone: (__)_____ (__)_____
Cell **Work (optional)**

Spouses Employer: _____ Occupation:_____

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

Extended Information (nearest relative)

Phone: (__)_____ (__)_____
Home **Cell**

Relationship_____

Address_____ City_____ State_____ Zip_____

ASSIGNMENT OF INSURANCE BENEFITS I hereby authorize direct payment of surgical/ medical benefits to Dr. Michael N. Rutman for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION I hereby authorize Dr. Michael N. Rutman, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE/MEDICAID I certify that the information given by me in applying for payment is correct. I authorize release of all records I request. I request that payment of authorized benefits be made on my behalf.

Patient (print)_____ Parent/ Guardian (print) _____

Signature_____(patient, parent or guardian) Date_____

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New Patient Packet

Patient Name: _____ Date: _____

Last/First **MM/DD/YYYY**

1. What is the primary reason that you are here today? _____

2. Approximate date of symptom(s) occurrence: _____

3. What type and duration of treatment(s) have you received for this condition or symptom(s) thus far (i.e., medication, please list type and duration of therapy, surgery, etc.): _____

4. Please list any allergies to medications or substances:

   ☐ **No known drug allergies**

5. Please list the name, dosage and frequency of any prescription medications that you take on a regular basis:

   ☐ **I am currently not taking any medication**

6. **Hospitalizations** (including any surgeries) Health Habits

Reason for hospitalization	Year	Health Habits	Describe Use
1		☐ Caffeine	
2		☐ Tobacco	
3		☐ Drugs	
4		☐ Alcohol	

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Patient Name: _____ Date: _____

Last/First **MM/DD/YYYY**

7. Past Health History

Please check any conditions that you have, or have had in the past:

☐ Alcoholism	☐ Anemia	☐ Arthritis	☐ Asthma	☐ Bleeding Disorder
☐ Bronchitis	☐ Cancer (type) _____		☐ Cataracts	☐ Chemical Dependency
☐ Diabetes	☐ Emphysema	☐ Epilepsy	☐ Glaucoma	☐ Goiter
☐ Gout	☐ Heart Disease	☐ Hepatitis (type) _____		☐ Hernia
☐ Herpes	☐ High Cholesterol	☐ HIV Positive	☐ Kidney Disease	☐ Migraines
☐ Multiple Sclerosis	☐ Pacemaker	☐ Pneumonia	☐ Polio	☐ High Blood Pressure
☐ Prostate Problem	☐ Psychiatric Care	☐ Rheumatic Fever	☐ Stroke	☐ Suicide Attempt
☐ Thyroid Problems	☐ Tuberculosis	☐ Typhoid Fever	☐ Ulcers	☐ Venereal Disease

8. Family History

Relation	Living/Age	Age at Death	Cause of Death	Disease	Relation
	☐ Y ☐ N _____			☐ Arthritis ☐ Gout	
Mother	☐ Y ☐ N _____			☐ Asthma	
Father	☐ Y ☐ N _____			☐ Hay Fever	
Brother(s)	☐ Y ☐ N _____			☐ Diabetes	
	☐ Y ☐ N _____			☐ Heart Disease	
	☐ Y ☐ N _____			☐ Tuberculosis	
Sister(s)	☐ Y ☐ N _____			☐ High Blood Pressure	
	☐ Y ☐ N _____			**Please check if any of the above listed diseases have been found in your relatives blood**	
	☐ Y ☐ N _____				

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Patient Name: _____ Date: _____

Last/First **MM/DD/YYYY**

9. Health History

Please check any conditions that you currently have, or have had in the past

Current Signs & Symptoms:

☐ Chills ☐ Depression ☐ Fainting ☐ Fever ☐ Forgetfulness

☐ Headaches ☐ Loss of Sleep ☐ Loss of Weight ☐ Nervousness ☐ Numbness

☐ Sweats

Skin:

☐ Bruise Easily ☐ Hives ☐ Itching ☐ Change in Moles ☐ Rash

☐ Scars sores that won't heal

*Please check any symptoms that you currently have or have had in the past **YEAR**:*

Ear:

☐ Dizziness ☐ Hearing Loss ☐ Pain ☐ Jaw Pain ☐ Loss of Balance

☐ Pressure ☐ Ringing ☐ Wax ***Nose/Sinus:***

☐ Allergies ☐ Bleeding ☐ Congestion ☐ Eye Pressure ☐ Eye Pain

☐ Forehead Pain ☐ Hay Fever ☐ Post Nasal Drip ☐ Mucous Plugs ☐ Nasal Drainage

☐ Pain in Cheek ☐ Headache ☐ Teeth/Gum Pain ☐ Watery Eye

Throat:

☐ Abscess ☐ Cough ☐ Difficulty Swallowing ☐ Hoarseness ☐ Lumps

☐ Mouth Sores ☐ Mucous ☐ Pain ☐ Strep Throat ☐ Swelling

☐ Tongue Pain ☐ Tongue Swelling ☐ Tonsillitis

Neck:

☐ Lumps ☐ Pain ☐ Swelling ☐ Thyroid Disease ☐ Thyroid Nodule

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Patient Name: _____ Date: _____

Last/First **MM/DD/YYYY**

Cardiovascular:

☐ Chest Pain ☐ High Blood Pressure ☐ Irregular Heart Beat ☐ Low Blood Pressure ☐ Poor Circulation

☐ Rapid Heart Beat ☐ Swelling of Ankles ☐ Varicose Vain

Lungs:

☐ Shortness of Breath ☐ Cough ☐ Production of Sputum ☐ Coughing up Blood

☐ Wheezing ☐ Rapid Breathing ☐ Shortness of breath while lying down

Gastrointestinal:

☐ Abdominal Pain ☐ Bloating ☐ Nausea ☐ Vomiting ☐ Diarrhea

☐ Constipation ☐ Blood in Stool ☐ Change in Stool ☐ Liver Disease ☐ Heartburn

☐ Rectal Pain

Urinary:

☐ Difficulty Urinating ☐ Burning Urination ☐ Frequent Urination ☐ Urinating at night ___ times

☐ Prostate Problems ☐ Bladder or Kidney Disease

Neuro-Muscular:

☐ Seizures ☐ Paralysis ☐ Weakness ☐ Dizziness ☐ Headaches

☐ Blurred Vision ☐ Double Vision ☐ Passing Out ☐ Tingling or weakness on one side of body or face

☐ Loss of Speech ☐ Loss of Vision

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Patient Name: _____ DOB: _____

Last/First **MM/DD/YYYY**

10. Previously Seen Physicians

Please list the names, addresses, and phone numbers of any doctors you have seen within the past five (5) years:

_____ ( ) _____

Doctors Name Telephone Number

_____

Address City State Zip

_____ ( ) _____

Doctors Name Telephone Number

_____

Address City State Zip

_____ ( ) _____

Doctors Name Telephone Number

_____

Address City State Zip

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Please print name

_____ _____

Please sign name Date MM/DD/YYYY