Practitioner Information Form

DATE: ______________________ **NAME:** ______________________________________

DATE OF BIRTH: __________________________ **GENDER:** __________________________

ETHNIC BACKGROUND: ______________________ **MARTIAL STATUS:** ____________________

PRACTITIONER TYPE: MD DO PA RESIDENT STUDENT Other: ________________

PHYSICIAN SPECIALTY: ____

Home Phone:___________________________ Can we leave a message? Yes No

Work:_________________________________ Can we leave a message? Yes No

Cell:_________________________________ Can we leave a message? Yes No

Email: ________________________________ Private e-mail account? Yes No

PREFERRED METHOD OF CONTACT:____

PREFERRED ADDRESS:____

____

EMERGENCY CONTACT:__________________________ **RELATIONSHIP:** ________________

PHONE:_____________________ **ADDRESS:** ____________________________________

____

ARE YOU CURRENTLY PRACTICING? YES NO

PRACTICE SETTING: N/A Solo Private Group Hospital HMO

Private Clinic Public Clinic Retired Other:____________

PLEASE LIST STATES IN WHICH YOU CURRENTLY HOLD A LICENSE:

1._____________________________ **2.**_____________________________

3._____________________________ **4**______________________________

HAVE YOU HELD A LICENSE IN ANY OTHER STATE: YES NO
IF YES, PLEASE LIST:

____

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PLEASE LIST ALL HOSPITAL AND HEALTH ORGANIZATION PRIVILEGES:

1.____

2.____

3.____

4. ____

REASON FOR YOUR VISIT:

___Alcohol Abuse
___Drug Abuse
___Psychiatric Illness
___Self Prescribing
___Sexual Misconduct
___Sexual Harassment
___Personality Problem
___Legal
___Anger Outbursts
___DWI
___Disruptive Behavior

___Other Specify:____

PLEASE COMMENT ON REASON(S) FOR VISIT:

____

____

____

____

MEDICAL CONDITIONS:

____

____

PRIMARY CARE PHYSICIAN:_________________________ **LAST PHYSICAL:**_________________

LIST OF ANY MEDICATIONS:

_____________________ _____________________

_____________________ _____________________

_____________________ _____________________

_____________________ _____________________

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