

PATRICK J. PROFFER, M.D.  
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AMARILLO, TX 79106  
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Patient's Full Name: \_\_\_\_\_ Name Preferred to be Called: \_\_\_\_\_ Sex: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Race: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Ph: (\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security No: \_\_\_\_\_  
Marital Status: (circle) M S W D Spouse's Name: \_\_\_\_\_  
Spouse's Social Security No: \_\_\_\_\_ Spouse's Birth Date: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

Responsible Party (if different than patient or spouse): \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Social Security No: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Responsible Party Home Ph: (\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_

If Referred by Another Physician – Physician Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_  
Primary Care Physician (if different from referring Physician): \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_ Phone # \_\_\_\_\_

**Primary Insurance Company**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
ID Number: \_\_\_\_\_  
Subscriber: \_\_\_\_\_  
Subscriber Social Security No: \_\_\_\_\_  
Subscriber DOB: \_\_\_\_\_

**Secondary Insurance Company**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
ID Number: \_\_\_\_\_  
Subscriber: \_\_\_\_\_  
Subscriber Social Security No: \_\_\_\_\_  
Subscriber DOB: \_\_\_\_\_

Patient's Employer (or retired from): \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Work Ph: (\_\_\_\_) \_\_\_\_\_

Spouse's (or Responsible Party's) Employer (or retired from): \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Work Ph: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Cell Ph: (\_\_\_\_) \_\_\_\_\_

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION BY PROFFER SURGICAL ASSOCIATES, LLP FOR ANY INSURANCE CLAIMS SUBMISSION AND AT THE DOCTOR'S DISCRETION, ASSIGN THE INSURANCE PAYMENT TO THEM FOR THESE SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES THAT ARE NOT COVERED.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**REASON FOR VISIT** \_\_\_\_\_ **DATE OF INJURY** \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Are you currently, or could you be pregnant? \_\_\_\_\_  
 Are you right or left handed? \_\_\_\_\_

**PAST AND CURRENT MEDICAL CONDITIONS**

**BREAST HISTORY (If applicable)**

Have you had previous breast surgery? Yes  No  If so, what type? \_\_\_\_\_  
 Do you have a history of breast cancer in your family? \_\_\_\_\_  
 If so, who and at what age? \_\_\_\_\_  
 When was your last mammogram? \_\_\_\_\_  
 Any concerns or abnormalities? \_\_\_\_\_  
 If you had children, did you breast feed? \_\_\_\_\_

PREVIOUS SURGERIES / DATES:	

Medications now taking or have taken in the last month (including doses)	DRUG ALLERGIES	OTHER ALLERGIES

Herbal Supplements/Vitamins (including doses)	

**SMOKING HISTORY** Do you smoke Yes  No   
 If so, how long have you smoked? \_\_\_\_\_  
 If so, how many pack/day? \_\_\_\_\_ If quit, how long ago? \_\_\_\_\_

**ALCOHOL USE** Do not use   
 Less than 6 drinks/week  6 or more drinks/week   
 Type \_\_\_\_\_

**Personal Medical History: Have you ever had or do you now have: (Check YES or NO)**

	YES	NO		YES	NO
1. SHORTNESS OF BREATH			22. EXCESSIVE SCARRING		
2. CHEST OR HEART PAIN/ANGINA			23. STOMACH OR DUODENAL ULCER		
3. ASTHMA			24. VOMITING BLOOD/BLACK STOOLS		
4. CHRONIC BRONCHITIS			25. RECENT GAIN OR LOSS IN WEIGHT		
5. FREQUENT COLDS/COUGH			26. HEMORRHOIDS		
6. HEART DISEASE OR ATTACK			27. HERNIA (GROIN OR ABDOMINAL)		
7. HIGH OR LOW BLOOD PRESSURE			28. KIDNEY TROUBLE OR NEPHRITIS		
8. HEART VALVE PROBS/MURMURS			29. PAINFUL OR BLOODY URINATION		
9. BREAST PROBLEMS/DISEASE			30. LOW BACK TROUBLE/BACKACHE		
10. RHEUMATIC FEVER			31. VARICOSE VEINS		
11. ANKLE SWELLING			32. BLOOD CLOTS		
12. EASY BRUISING			33. RADIATION THERAPY		
13. EXCESSIVE BLEEDING			34. EPILEPSY OR SEIZURES		
14. ANEMIA OR BLOOD DISEASE			35. EMOTIONAL/PSYCHIATRIC PROBLEMS		
15. THYROID DISEASE			36. FREQUENT OR SEVERE HEADACHES		
16. SUGAR OR ALBUMIN IN URINE			37. AIDS OR HIV		
17. DIABETES			38. FACIAL PARALYSIS OR NUMBNESS		
18. SKIN CANCER			39. LIMITED ACTIVITY		
19. ARTHRITIS/JOINT PROBLEMS			40. ANESTHESIA PROBLEMS		
20. CHRONIC DIARRHEA/BOWEL TRB.			41. HERPES OR FEVER BLISTERS		
21. HEPATITIS/JAUNDICE/LIVER TRB.					

Please list any other medical conditions:

\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_