PAUL L. PROFFER, MD, FACS, PA
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AMARILLO, TX 79106
(806) 355-3532

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 (Full time____) (Part time____) (Retired_____):____
Address:____ City/State/Zip:____________________________________
Work Ph: (____)____

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

Emergency Contact:_______________________________
Address:____
Phone: (____)______________________________________

Relationship:________________________________
City/State/Zip:______________________________
Cell Ph: (____)______________________________

REASON FOR VISIT:____
DATE OF INJURY:____

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 THEMFOR THESE SERVICES, I UNDERSTAND THAT I AM FINANCILLY RESPONSIBLE FOR THE CHARGES THAT ARE NOT COVERED.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:____
DATE: ____

Have you been hospitalized in the last five years:_________________________ If so, for what:
____
____

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. DIZZINESS		
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.					

Smoking History
Do you Smoke?__________ If so how long have you smoked: ________________________________
If so how many packs/day______________________ If quit how long ago___________________________

If allergic to medications or drugs, indicate which
ones:____

What Medications are you currently taking and what
for:____

Other Physical
Conditions:____

Family
History:____
____

Are you receiving other health care?_________________________ If so, please indicate the nature of the
care:____
____
____

Name of other
Physician:____
Address:____
Phone: (   )____

Patient Signature: Date: