PATRICK J. PROFFER, M.D.
1611 Wallace Blvd.
AMARILLO, TX 79106
(806) 352-1185

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.

PREFERRED PHARMACY_____
PHONE:_____

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?_____ Do you have a pacemaker or defibrillator: _____

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 or vape Yes □ No □
If so, how long have you smoked? _____
If so, how much?_____ If quit, how long ago?_____

ALCOHOL OR ILLICIT DRUG USE Do not use □
Less than 6 per week □ 6 or more per 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 _____