LIANA H. PROFFER, M.D. SUMMER CLARK M.D.
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AMARILLO, TX 79106
(806)354-4900

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: _____
E-Mail Address:_____

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 Name:_____
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:_____ 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: _____

MEDICAL HISTORY

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

	YES	NO		YES	NO
1. SHORTNESS OF BREATH			11. DIABETES		
2. CHEST OR HEART PAIN/ANGINA			12. SKIN PROBLEMS		
3. HEART DISEASE OR ATTACK			13. ARTHRITIS/JOINT PROBLEMS		
4. HIGH BLOOD PRESSURE			14. THYROID DISEASE		
5. HEART VALVE PROBS/MURMURS			15. HEPATITIS/JAUNDICE/LIVER TRB.		
6. EASY BRUISING			16. CANCER/TUMOR (OTHER THAN SKIN CANCER)		
7. EXCESSIVE BLEEDING			17. AIDS OR HIV		
8. ANEMIA OR BLOOD DISEASE			18. BLOOD CLOTS		
9. DO YOU USE BLOOD THINNERS? IF YES, NAME & DOSE_____			19. ANESTHESIA PROBLEMS		
10. DO YOU HAVE AN IMPLANTABLE DEFIBRILLATOR?			20. DO YOU HAVE A PACEMAKER?		
			21. DO YOU TAKE ANTIBIOTICS PRIOR TO ANY DENTAL PROCEDURES?		

Have you had a pneumonia vaccination? _____ yes _____ no. If yes, what was the date: _____

Have you had a flu vaccination? _____ yes _____ no. If yes, what was the date: _____

List Surgeries AND Dates:_____

Cardiologist Name:_____ Primary Care Physician:_____

Do you have a pacemaker or defibrillator? _____

Do you have cardiac stents? Yes □ No □

SKIN CANCER HISTORY

Basal Cell Carcinoma Yes □ No □ / Squamous Cell Carcinoma Yes □ No □ / Melanoma Yes □ No □ / Other Yes □ No □

Have you ever been treated with Mohs Surgery? Yes □ No □

Do you have a history of abnormal scarring? Yes □ No □

SMOKING HISTORY

Do you smoke/vape Yes □ No □

If so, how long have you Smoked/Vaped?_____

If so, how many pack/day? _____

If quit, how long ago? _____

ALCOHOL SCREENING:

Did you have a drink containing alcohol in the past year? Yes □ No □

If yes -

How often did you have six or more drinks on one occasion in the past year? _____

How many drinks did you have on a typical day when you were drinking in the past year? _____

How often did you have a drink containing alcohol in the past year?

_____

Do you take illicit drugs: Yes □ No □

FAMILY HISTORY: If any blood relatives has suffered any of the following – please indicate which relative.

Bleeding Problems _____ Heart Disease _____

Melanoma _____ Anesthesia Problems _____

Diabetes _____ Other _____

COMMENTS (Please let us know if you suspect pregnancy during any part of our treatment)

_____

_____

PREFERRED PHARMACY: _____ PHONE NUMBER: _____

Patient Signature_____ Date _____

Patient Name: _____ Date: _____

Please list ALL drug allergies and reactions

Medication	Reaction

Please list ALL medications, vitamins and over-the-counter medications taken:

Medication	Dosage	Frequency Taken

Continue on back if needed

Patient Name: _____ Date: _____

Please list ALL drug allergies and reactions

Medication	Reaction

Please list ALL medications, vitamins and over-the-counter medications taken:

Medication	Dosage	Frequency Taken