Patient Information					
Name	Date of Birth		Age		
Birth Sex: M or F Identified GenderRace/Ethnicity					
Marital Status	Marital StatusOccupation				
Address	City	State_	Zip		
Cell Phone Hom	e Phone	Email			
How did you hear about us?					
Insurance Information					
Primary Insurance					
Address					
Policy No Group No					
Secondary Insurance					
Address					
	Group No				
Communication Authorization					
I, authorize the staff of Pamela S. Kennedy, M.D. to notify					
me of my diagnostic/lab results over the telephone by either of the following:					
Speak directly with myself or	authorized person <i>OR</i> _	Okay to leave a void	cemail message		
List any other persons authorized to accept results or make changes to appointments:					
Name	Relationship	Phone			
Name	Relationship	Phone			
Name	Relationship	Phone			

Name	Patient History				
Primary Care Physician (PCP)	Name	Date of Birth	Height Weight		
Please list all Medications: Please list all Allergies: Check if you have any of the following: Pacemaker Blood Thinners/Aspirin Irregular Heartbeat Heal: Thick Scar Joint Pain High Blood Pressure Seizures Hay Fever Hepatitis Pregnant/Planning/Breastfeeding Asthma Artificial Valves/Joints Diabetes Thyroid Disorder: Hyper/Hypo Immune Deficiency/HIV Depression Liver Disease Gl/GERD (Reflux) Other (please explain) Do you have a history of skin cancer? Yes or No If yes, which type? Do you have a family history of Melanoma? Yes or No If yes, relation? Do you smoke cigarettes? Yes or No Do you consume alcohol? Yes or No For Females only: Are you having menstrual cycles? Yes or No Date of last menstrual cycle Have you had a hysterectomy? Yes or No Are you sexually active? Yes or No Form of Contraception By signing below, I certify all information is true and correct to the best of my knowledge. By signing below, I certify all information necessary to file a claim with my insurance company, if applicable. I understand I am financially responsible for any balance not covered by my insurance carrier once a claim is filed. *Please speak to your provider before a procedure is performed should you have a question regarding procedure cost.	Reason for today's visit				
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Please list all Allergies: Pacemaker	Pharmacy	Address			
Check if you have any of the following: Pacemaker	Please list all Medications:				
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	Signature	Date			