ZOE DIANA DRAELOS, MD, PA
2444 North Main Street
High Point, NC 27262

ACCT#____________

PATIENT INFORMATION

DATE________________________ REFERRED BY DR.____

NAME____
LAST FIRST MIDDLE PREFERRED NAME

STREET ADDRESS____

CITY_____________________________________ STATE___________________ ZIP_________________________

HOME PHONE (   )_______________-____________ CELL PHONE (   )_____________-______________

E-MAIL____

DATE OF BIRTH__________________________ GENDER__________________ RACE________________________

SOCIAL SECURITY__________-__________-___________ MARITAL STATUS_______________________________

EMPLOYER/SCHOOL____________________________________ OCCUPATION_____________________________

EMPLOYER ADDRESS_______________________________________WORK PHONE (   )_________-___________

EMERGENCY CONTACT_________________________________ RELATIONSHIP__________________________

HOME PHONE__________________CELL PHONE_________________WORK PHONE______________________

PLEASE PRESENT INSURANCE CARD(S) TO THE RECEPTIONIST

I authorize that payment of authorized insurance benefits be made on my behalf to Zoe Diana Draelos, MD, PA for any services furnished to me by her. I authorize any holder of medical information about me to release to the insurance company or governmental agency and its agents any information needed to determine these benefits or the benefits payable for related services. I authorize the use of my name while in the medical office.

I am responsible directly to Zoe Diana Draelos, MD, PA for payment on my account regardless of the status of medical insurance claims. Any medical supplies, medications, and cosmetic procedures will be paid for at the time of service. Cosmetic procedures cannot be filed with insurance. Payment is acceptedin the form of cash, check, credit card or debit card.

SIGNATURE____DATE________________

PLEASE COMPLETE MEDICAL HISTORY SECTION ON BACK

MEDICAL HISTORY

Are you currently being treated for or do you have a history of any of the following:

	YES	NO
1. AIDS/HIV	☐	☐
2. ANEMIA (Iron Deficiency)	☐	☐
3. ASTHMA	☐	☐
4. CANCER______________________________	☐	☐
5. DIABETES	☐	☐
6. HAY FEVER	☐	☐
7. HEART PROBLEMS____________________	☐	☐
8. HEPATITIS/JAUNDICE	☐	☐
9. HYPERTENSION (High Blood Pressure)	☐	☐
10. KIDNEY PROBLEMS_________________________	☐	☐
11. LIVER PROBLEMS___________________________	☐	☐
12. PACEMAKER	☐	☐
13. PHLEBITIS (Blood Clots)	☐	☐
14. STOMACH ULCERS/HIATAL HERNIA	☐	☐
15. THYROID CONDITION	☐	☐
16. OTHER_______________________________________	☐	☐

Current Medication(s): ____

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Drug Allergies: ____

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