South Shore Infectious Diseases
& Travel Medicine Consultants, P.C.
A.I.M.S- Antibiotic Infusion Medical Suite

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Birthdate: _____/_____/_____ Sex: M____ F_____

Address: _____ City: _____ Zip:_____

Home #: (_____) _____ Cellphone #: (_____) _____

Email: _____

INSURANCE INFORMATION:

PRIMARY

Insurance Company: _____
Member ID: _____ Group ID: _____ Specialist Copay: $_____
Claims Address: _____ City: _____
State: _____ Zip Code: _____ Policy Holder Birthdate:_____
Policy Holders name:_____ Relationship to Patient: _____

SECONDARY

Insurance Company: _____
Member ID: _____ Group ID: _____ Specialist Copay: $_____
Claims Address: _____ City: _____
State: _____ Zip Code: _____ Policy Holder Birthdate:_____
Policy Holders name:_____ Relationship to Patient: _____

WORKERS COMPENSATION OR NO FAULT INFORMATION:

Case Number: _____ Date of Accident: _____

Adjusters Name and Phone Number: _____

Name of Insurance: _____

Claims Address: _____

Marital Status (Circle one) Married Single Divorced Widowed

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino

Race: ___African American ___Asian ___White/Caucasian ___American Indian ___Other

PRIMARY CARE DOCTOR: _____

OTHER SPECIALISTS TREATING YOU:_____

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Name: _____

Allergies: ___Penicillin ___Sulfa ___Codeine ___Other: _____

MEDICATIONS: (Please list name AND dosage)

_____ _____ _____
_____ _____ _____
_____ _____ _____

SURGERIES:

_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICAL HISTORY (Check all that apply)

- o Anemia
- o Arthritis
- o Asthma
- o Blood Transfusion
- o Cancer: _____
- o Chronic Heart Failure
- o COPD
- o Diabetes
- o Depression
- o Emphysema
- o GERD
- o Gout
- o Heart Disease or Heart Attack
- o HIV/AIDS
- o High Cholesterol
- o High Blood Pressure
- o Kidney Disease
- o Liver Disease/Hepatitis
- o Meningitis
- o Osteoporosis
- o Stroke
- o Substance Abuse
- o STD's
- o Thyroid Disease
- o Ulcers
- o Tuberculosis

Additional Medical History: _____

FAMILY HISTORY: (Parents, Siblings, Aunts, Uncles): _____

Weight: _____ Height: _____ Alcohol Use: ____ YES ___ NO Frequency:_____

Tobacco Use: ____ YES ___NO Tobacco Type: ___ E-cigarette ___Cigarettes ___Cigars ___Pipe
Packs/Day: ___1/4 ___1/2 ___1 ___1.5 ___2 YEARS: ___<1 ___<5 ___10 ___15 OTHER:_____
Quit Date: _____

DRUG USE: (Please circle one) YES NO
If YES: ___Cocaine ___Heroin ___Marijuana ___Oxycodone Other: _____

When was your last:
Colonoscopy: _____ Flu vaccine: _____ Mammogram: _____
Pap: _____ Pneumonia Vaccine: _____

Pharmacy NAME and TOWN: _____