

# NEW PATIENT QUESTIONNAIRE



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|----------------|--|-------------|------------|
| <b>Name</b>    |  | <b>Date</b> |            |
| <b>Address</b> |  | <b>DOB</b>  | <b>Age</b> |

| MEDICATIONS |  |  |
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| PAST MEDICAL HISTORY |  |  |
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| PAST SURGICAL HISTORY |  |  |
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| ALLERGIES |  |  |
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| <b>Insurance</b> |  | <b>Previous Physician</b> |  |
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| <b>Phone:</b> |  |
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