HD ___/___

John Parkerson, M.D., M.S.

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410-366-3627

TODAY'S DATE_____2015
Month Day

NAME_____
Last First Middle Initial

Who referred you to this office? _____

SOCIAL SECURITY NUMBER _____ - _____ - _____

ADDRESS _____
Street City State Zip Code

DATE OF BIRTH _____19_____ _____ GENDER Male Female
Month Day Year AGE

TELEPHONE _____ - _____ Right Handed Left-Handed
Area Code

ALLERGIES Hay fever / seasonal Penicillin OTHER _____

CURRENT MEDICATIONS (by prescription or over-the-counter) I have a list that can be copied

_____

CURRENT MEDICAL PROBLEMS High Blood Pressure Diabetes Asthma Heart Sleep Apnea

High Cholesterol OTHER _____

_____

OPERATIONS Tonsillectomy Appendectomy Hysterectomy Tubal Ligation
Vasectomy Hernia Gall Bladder Cataract Bunion Sinus

OTHER (type of operation and year) _____

_____

1. ___ ___ ___ ___.___ ___ 5. ___ ___ ___ ___.___ ___ 9. ___ ___ ___ ___.___ ___
2. ___ ___ ___ ___.___ ___ 6. ___ ___ ___ ___.___ ___ 10. ___ ___ ___ ___.___ ___
3. ___ ___ ___ ___.___ ___ 7. ___ ___ ___ ___.___ ___ 11. ___ ___ ___ ___.___ ___
4. ___ ___ ___ ___.___ ___ 8. ___ ___ ___ ___.___ ___ 12. ___ ___ ___ ___.___ ___

FR EM HG LA FILE 15 ___ ___ ___ ___

Name_____
Last First Middle Initial

CURRENT TREATING PHYSICIANS _____

HOSPITALIZATIONS (reason for admission and year)_____

_____

WORK INJURIES (part injured and year) _____

_____

MOTOR VEHICLE ACCIDENTS and OTHER INJURIES (part injured and year) _____

_____

TOBACCO USE None Quit Smoking Year _____ Less than 1 pack per day

1 pack per day More than 1 pack per day Cigars Pipe Chew

ALCOHOL USE None Rarely Drink Social Drinker Other

History of alcoholism History of treatment for alcoholism/substance abuse

MARTIAL STATUS Single Married Other Number of Children _____

HIGHEST EDUCATIONAL LEVEL Grade _____ GED HS Years of College _____

AA BA BS Other _____

CURRENT STUDENT NO YES Full-Time Part-Time

CURRENT EMPLOYER _____

OCCUPATION / JOB TITLE _____

HOW LONG WITH CURRENT EMPLOYER (years or start date) _____

My Last Day at Work was _____ Today
Month Day Year

NOT CURRENTLY EMPLOYED RETIRED SOCIAL SECURITY DISABILITY

MILITARY SERVICE NONE Navy Army Marine Air Force Reserve

Years of Service _____ Year Discharged _____

HEIGHT _____ ft _____in WEIGHT _____ pounds

FR EM HG LA FILE 15 ___ ___ ___ ___ 2

I, _____(print name) agree to the following:

The information supplied to Dr. Parkerson is true and complete to my best knowledge.

I consent to Dr. Parkerson's review of my medical records and his clinical examination. Medical records and bills generated from this evaluation will be sent to the referral source (for example the insurance company, my attorney, or my employer). Requests for copies of Dr. Parkerson's report must first be directed to the referral source.

If the insurance company or my employer has referred me for examination, I am not responsible for Dr. Parkerson's charges. If I have been referred for examination by my attorney or myself, I remain fully responsible to pay Dr. Parkerson's fee and any reasonable collection costs that he incurs regardless of insurance coverage or outcome of any litigation.

I understand if my examination is for the purpose of an independent medical evaluation or defense medical examination, Dr. Parkerson will not become my treating physician or give me medical advice regarding prognosis or recommendations for further care.

I authorize Dr. Parkerson to release any medical information necessary to process my claim.

SIGNATURE _____

_____
DATE

WITNESS _____

_____
DATE