

De Queen Clinic, P. A.
1314 W. Collin Raye Drive, De Queen, AR 71832

Patient Information

First Name: _____ MI: ____ Last: _____

Social Security Number: _____ Chart #: _____

Sex: M F Birth Date: ___/___/___ Marital Status: M S D W

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

Have other members of your immediate family ever been a patient of Dr. Buffington's? Yes / No.

If so, what are their name(s): _____

If a patient is a minor (under 18), please name responsible parent and address:

Please give name and number of friend or relative not living at your address:

If you have insurance please give your card to the receptionist.

I authorize the physician and or the designates to provide medical treatment and release information pertaining to my treatment for insurance purpose and release information pertaining to my treatment to any health care provider to whom he/she may refer me. I hereby request that payment under the medical insurance program be made either to me or to the physician for charges therein. I certify that the above information is correct and I understand that I am responsible for all bills regarding of insurance coverage of any kind. A photocopy of the assignment is to be considered as valid as the original.

Responsible Party Signature

Date

Name: _____

Serious Illnesses: _____

Operations: (circle all that apply)

Tonsils	Appendix	Uterus	Ovaries
Colon	Stomach	Heart	Ears
Lung	Hernia	Gallbladder	

Other: _____

Allergies: Penicillin Sulfa Other: _____

Family History

Cancer? Yes / No If yes, who: _____

Diabetes Mellitus If yes, who: _____

Anemia? Yes / No If yes, who: _____

Heart Disease? Yes / No If yes, who: _____

Habits: (Circle all that apply) Seatbelts Tobacco Alcohol Addicting Drugs

Last Flu or Pneumonia Shot: _____

Female Only: Last Normal Period Date: _____ Children? _____

Family History of Osteoporosis? Yes / No If yes, who: _____

Circle all the following that normally apply to you:

Headaches	Acid Stomach
Paralysis	Constipation
Seizures	Diarrhea
Sinus Trouble	Burning on Urination
Glasses	Kidney Stones
Dentures	Frequency of Urination
Clogged Arteries	Broken Bones
Irregular Heart Beat	Muscle Aches
Enlarged Heart	Depression
Shortness of Breath	Nervousness
Asthma	Poor Sleep
Bronchitis	Other _____