PETER V.P. DANGVU, M.D., INC.
17742 BEACH BLVD SUITE 340
HUNTINGTON BEACH, CA 92648
PHONE: (714) 842-7600
FACSIMILE: (714) 842-7654

DATE		
MONTH	DAY	YEAR
		2011

Patient Information

LAST NAME	FIRST NAME	M.I.

ADDRESS

CITY, STATE

PATIENTS EMPLOYMENT NAME/ADDRESS	OCCUPATION

WORK PHONE NUMBER	CELL PHONE NUMBER
E-MAIL ADDRESS	HOME PHONE NUMBER

Personal Information

DATE OF BIRTH	SEX M or F	AGE	SOCIAL SECURITY #

MARITAL STATUS M S W D	DRIVERS LICENSE #

SPOUSE

SPOUSE'S BUSINESS NAME, ADDRESS & PHONE NUMBER

SPOUSE'S OCCUPATION	SPOUSE'S DATE OF BIRTH & SOCIAL SECURITY #

PERSON TO CONTACT IN CASE OF EMERGENCY	ADDRESS/PHONE NUMBER

INSURANCE INFORMATION (Must be completed for Billing)

PRIMARY INSURANCE CO.	PRIMARY CARD HOLDER/DOB
	CERT#/SS# OF PRIMARY CARD HOLDER
ADDRESS, CITY, STATE, ZIP	GROUP #
PHONE NUMBER: ( )	RELATIONSHIP:

SECONADRY INSURANCE CO:	SUBSCRIBER/DOB/CERTIFICATE & GROUP #
ADDRESS	

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize the above named doctor to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that the office will bill my insurance company as a courtesy, and that I am financially responsible for any and all charges not covered or allowed by my insurance benefits. **Patient's Signature**_____

NAME _____ **DATE**_____

PAST MEDICAL HISTORY

Please check any of the following conditions that you have or have had in the past:

[ ] Anemia	[ ] Asthma	[ ] Schizophrenia
[ ] Diabetes	[ ] Emphysema	[ ] Depression
[ ] Thyroid problems	[ ] Pneumonia	[ ] Gout
[ ] Angina	[ ] Seizures	[ ] Tuberculosis
[ ] Abnormal heart rhythm	[ ] Stroke or TIA	[ ] Alcohol addiction
[ ] Heart attack	[ ] Migrane Headaches	[ ] HIV or AIDS
[ ] Heart failure	[ ] Colitis	[ ] Cancer
[ ] High blood pressure	[ ] Hepatitis	[ ] Chlamydia
[ ] Murmur	[ ] Peptic ulcer disease	[ ] Gonorrhea
[ ] Rheumatic Fever	[ ] Kidney Stones	[ ] Herpes
[ ] Elevated cholesterol	[ ] Glaucoma	[ ] Genital Warts

Do you exercise? <3x/ week >3x/ week

Do you currently smoke cigarettes? Y N

If yes, how many per day? _____

How many drinks of alcohol do you consume per week?

0 <6 <12 <24 >24

Level of Education? (Please circle)

High School College Graduate School

OB/GYN History (Female Patients)

of Pregnancies? _____ # of Miscarriages? _____

Last Pap smear? _____ Last Mammogram? _____

Doctor's Name?_____ Last Bone Denisty?_____

Family History

Please check the appropriate family medical history:

Medical Condition	Father	Mother	Father's parents	Mother's Parents	Siblings
High Blood pressure	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Attack	[ ]	[ ]	[ ]	[ ]	[ ]
Blood disorder	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]
Schizophrenia	[ ]	[ ]	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]	[ ]
Migrane headaches	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]	[ ]	[ ]
Colitis	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney problem	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ] (Type) _____

Medications: _____

_____

_____

OTHER MEDICAL HISTORY

List any other medical conditions that you have been diagnosed with:

_____

_____

_____

_____

SURGICAL HISTORY

List all surgeries that you have had:

_____

_____

MOTHER LIVING: Y N

Health status or cause of death:

_____

FATHER LIVING: Y N

Health status or cause of death:

_____

MARITAL STATUS: S M D W

CHILDREN: Y N

IMMUNIZATIONS:_____

_____

LAST TETANUS? _____

_____

(Please give a copy of immunization card).

Allergies:_____