JULIAN E. MARTINEZ, M.D. P.C.

(For office use only)

Primary Insurance.: _____
Secondary Insurance.: _____
Special notes/ Instructions: _____

Lab to be used:
Labcorp (we bill) ___
Labcorp (lab bills) ___
QUEST (lab bills) ___

PATIENT INFORMATION (PLEASE PRINT)

Today's date: ____/____/_____ Date of birth: ____/____/_____ Age: _____

DRUG ALLERGIES: _____

Your full, legal name: _____
Your name as it appears on your insurance card: _____

Social Security #: _____-_____-_____

Marital Status (please circle one): Single Married Separated Divorced Widowed Other

HOW YOU'D LIKE TO BE ADDRESSED or nickname: _____ Maiden name or other used name: _____

Home address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home phone #: ( ) _____ (can we leave a detailed message? YES / NO)
Work phone #: ( ) _____ (can we leave a detailed message? YES / NO)
Cell phone #: ( ) _____(can we leave a detailed message? YES / NO)
Email address: _____

Your place of employment: _____Occupation: _____
Employer's address: _____

**** Name of Spouse or responsible party: (if other than yourself)** _____
Relation to you (please circle one) Spouse Parent Other(specify)_____
Responsible party's address (if different than your address) _____
Place of employment _____ Occupation _____
Work phone #: ( ) _____X_____ Social Security #: _____-_____-_____

In case of EMERGENCY, whom would you like us to contact:
Name: _____ Relationship: _____Phone #: ( ) _____X____

***Primary Insurance Co.:_____ Phone: ( ) _____**
Policy holder's name: _____ Social Security #: _____-_____-_____
Policy holder's date of birth _____
Your relationship to Policy holder (please circle one) Self Spouse Parent Other (specify) _____

***Secondary Insurance Co.: _____ Phone: ( ) _____**
Policy holder's name: _____ Social Security #: _____-_____-_____
Policy holder's date of birth _____
Your relationship to Policy holder (please circle one) Self Spouse Parent Other (specify)

PATIENT SIGNATURE: _____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY'S SIGNATURE: _____

Julian E. Martinez, M.D., P.C.
PATIENT HISTORY QUESTIONARE

Name:_____ D.O.B.____/____/____Today's Date: ____/____/____

Name of Primary Care Physician: _____ Who Referred you? _____

Reason for visit: _____

DRUG ALLERGIES: _____

Number of Pregnancies: _____ Number of Children Born: _____

MEDICAL HISTORY

Please list any medical issues you have:

_____
_____
_____
_____

Please list any medical issues in your family:

_____
_____
_____
_____

Please list any surgeries you have had:

_____
_____
_____
_____

Do you take any medications? If so please list them here:

_____
_____
_____
_____

How old were you when you had your first menstrual cycle? _____
Are your menstrual cycles regular? Y N How many days apart are they? _____
Duration? _____
When was your last Pap smear? _____
Have you ever had an abnormal Pap smear? Y N When? _____
How was it treated? _____
When was your last mammogram? _____

Patient's Signature: _____ Date: _____

Provider's Signature: _____ Date: _____