Date: _____

Account #: _____ Chart #: _____

Name:_____ S.S #: _____ Phone#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-Mail Address: _____ Cell Phone: _____

Age: _____ Birthdate: _____ Race: _____ Sex: _____ Marital Status: _____

Referred By: _____ Allergies: _____

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Spouse's Name: _____ Birthdate: _____ SS#: _____

Spouse's Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Nearest Relative (not living with you): _____

Relationship to Patient: _____ Phone: _____

Person Responsible: _____ SS#: _____Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Phone: _____
Policyholder's Name: _____ ID#: _____ Group#: _____
Policyholder's DOB: _____ Policyholder's SS#: _____
Secondary Insurance: _____Phone: _____
Policyholder's Name: _____ ID#: _____ Group#: _____
Policyholder's DOB: _____ Policyholder's SS#: _____

Patient or Authorized person's signature. I authorize the release of my medical or other information necessary to process my claims. I also request payment of governmental benefits either to myself or to the party who accepts assignment.

Insured's or authorized person's signature. I authorize payment of medical benefits to Dr. Yoshinobu Namihira for services rendered. Patient is responsible for any charges not covered by insurance.

Note: The place (Endoscopy Center) of the procedure is owned by the Physician (Dr. Yoshinobu Namihira).

Signature: _____ Date: _____ Signature: _____ Date: _____

Yearly Update Signature of Patient and/or Responsible Party

Signature: _____ Date: _____ Signature: _____ Date: _____

Signature: _____ Date: _____ Signature: _____ Date: _____

BETTER LIVING MEDICAL CLINIC
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Diplomate, American Board
Internal Medicine, Gastroenterology
Phone # (601) 638 -9800
Fax # (601) 638-9808

Patient Information

Date: _____

Name: _____

Allergies: _____

_____

_____

Past Medical History: _____

_____

_____

_____

Past Surgical History: _____

_____

_____

_____

Family History: _____

_____

_____

_____

Habits: Smoking _____ If so, how many years? _____
Alcohol _____
Coffee _____
Tea _____
Coke _____
Water _____

Medications: _____

_____

_____

_____

Patient's Name: _____
DOB: _____ Chart Number:
_____

Date	Allergies	Reaction	Initials

Update for History and Physical **Date:** _____

Patient Name: _____ **Chart#**: _____

Allergies:	**Medical Hx:**	**History of Surgeries:**
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____
5._____	5._____	5._____

Summary of Current Medications and Prescribing Physician (s):

1._____ 13._____

2._____ 14._____

3._____ 15._____

4._____ 16._____

5._____ 17._____

6._____ 18._____

7._____ 19._____

8._____ 20._____

9._____ 21._____

10._____ 22._____

11._____ 23._____

12._____ 24._____