Dr. Seaborn Hunt M.D.
150 SE 17th St., Suite 703
Ocala, FL 34471

INFORMATION

NAME: ______________________ D.O.B. ______________ SS# ______________

ADDRESS: ______________________ CITY/STATE: ______________ ZIP: __________

HOME PHONE: ______________ CELL: ______________ WORK: ______________

MARITAL STATUS (circle one) Married Single Divorced Widowed Separated

Height ________ Weight ________ Race ______________ Ethnic Group ________ Hispanic ________ Non Hispanic

OCCUPATION: ______________________ EMPLOYER: ______________________

HUSBAND'S NAME: ______________________ D.O.B. ______________ SS# ______________

EMPLOYER: ______________________ OCCUPATION: ______________________

IN CASE OF EMERGENCY NOTIFY: ______________________ PHONE: ______________

Otherwise note changes below

Personal history: Please check if you have ever had the following:

__ Heart Disease
__ High Blood Pressure
__ Rheumatic Fever
__ Thyroid Disease
__ Kidney Disease
__ Other Veneral Disease
__ Hepatitis
__ Other Liver Disorders
__ Asthma
__ Diabetes
__ TB
__ Headaches
__ Epilepsy
__ Anemia
__ Blood Clots
__ Des Exposure
__ Mononucleosis
__ Depression
__ Gonorrhea
__ Syphillis
__ AIDS

List any illness not checked above:

____

Are you allergic to any medications? Please list

____

Previous Surgery and Dates:

Surgery: ______________________ Date: ______________

Surgery: ______________________ Date: ______________

Surgery: ______________________ Date: ______________

List any medications your are currently taking:

____

____

List other physicians that you see and for what treatment:

____

Do you smoke (circle one) YES NO How Much? ______________

Do you have any children? YES NO

BOYS ____________ Ages ________ Health Problems ______________________

GIRLS ____________ Ages ________ Health Problems ______________________

Have you had any miscarriages? Yes (How many?) ________ No ________

CONFIDENTIAL INFORMATION FOR SEABORN M. HUNT, M.D.

FAMILY HISTORY:

FATHER'S NAME: ______________________________ PHONE: ______________

AGE: __________ HEALTH PROBLEMS: ______________________________

ADDRESS: ____

MOTHER'S NAME: ______________________________ PHONE: ______________

AGE: __________ HEALTH PROBLEMS: ______________________________

ADDRESS: ____

FAMILY HISTORY OF DISEASES (CIRCLE IF THEY APPLY)

MOTHER'S SIDE: — DIABETES TB BREAST CANCER HEART DISEASE CANCER

FATHER'S SIDE: — DIABETES TB HEART DISEASE CANCER

Is the patient a student? NO_____ YES_____ Full Time_____ Part Time_____

Religion: ______________________________

Do you have a Living Will: YES_____ * NO_____

Are you an Organ Donor: YES_____ * NO_____

IF YOU WOULD LIKE US TO HAVE A COPY, PRESENT THEM TO THE RECEPTIONIST.

LABS AND PATHOLOGY SENT FROM OUR OFFICE TO A LABORATORY WILL BE BILLED TO YOUR INSURANCE COMPANY OR YOU BY THE LAB PERFORMING THE TEST.

I, HEREBY AUTHORIZE SEABORN M. HUNT, M.D., TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF EXAM OR TREATMENT TO MY INSURANCE COMPANY. I AUTHORIZE PAYMENT DIRECTLY TO SEABORN M. HUNT, M.D. AND I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE DUE.

DATE: ____________________ **SIGNATURE:** ______________________________

IN ORDER FOR US TO TALK TO A RELATIVE OR FRIEND ABOUT APPOINTMENTS, LAB RESULTS OR OTHER INFORMATION, WE NEED YOUR PERMISSION TO TALK TO THEM. **YOU MAY RELEASE OR DISCUSS MY MEDICAL INFORMATION WITH:**

NAME: ______________________________ RELATIONSHIP: ______________

NAME: ______________________________ RELATIONSHIP: ______________

PATIENT SIGNATURE: ______________________________ DATE: ______________

RESPONSIBLE PARTY IF PATIENT IS A MINOR: ______________________________ DATE: ______________