801 Beville Rd.
Suite 201
South Daytona, FL 32119

Jason R. Mercer, M.D.
Patient Information Form

Phone: (386) 322-5200
Fax: (386) 767-0062

Name: _____

D.O.B. _____ SSN # _____

Local Address: _____

Home # _____ Cell # _____ Preferred Method of Contact: _____

Email: _____ Pharmacy: _____

Other Address : _____ Other Phone # _____
(If Temporary Resident)

Work Info

Employer Name: _____ Telephone Number: _____

Address: _____ Position: _____

Insurance Info (Please present all insurance cards to the receptionist. We can not bill your insurance without a copy of the card)

Primary Insurance Company: _____

Secondary Insurance Company: _____

Emergency Contact Info

In an emergency, if you are unable to make a decision about your medical care, who should we contact?

_____

Relationship to you: _____ Telephone Number: _____

Office Policy

This practice participates with Medicare and a limited number of private insurances. The patient will be responsible for any deductibles or copayments. Payment for these charges is expected when services are rendered unless prior arrangements have been made. If you have any questions about your insurance, please feel free to ask.

I hereby authorize this medical practice to furnish information concerning my medical condition and treatments to my insurance company. I hereby assign to this practice payments made by my insurance company for medical services rendered to myself and my dependents. I understand that I will be responsible for any deductible, copayments or services not covered by my insurance.

Signature: _____

Date: _____

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Patient Name: _____

Have you or any of your immediate relatives had any of the following medical conditions?

	SELF	MOTHER	FATHER	CHILDREN	SIBLINGS
ANEMIA	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐
BLOOD TRANSFUSIONS WHAT YEARS:_____	☐	--	--	--	--
CANCER TYPE:_____	☐	☐	☐	☐	☐
CATARACTS	☐	☐	☐	☐	☐
COLITIS	☐	☐	☐	☐	☐
DEPRESSION	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐
DIVERTICULOSIS	☐	☐	☐	☐	☐
EMPHYSEMA	☐	☐	☐	☐	☐
GOUT	☐	☐	☐	☐	☐
HEART ATTACK	☐	☐	☐	☐	☐
HEART MURMUR	☐	☐	☐	☐	☐
OTHER:_____					

	SELF	MOTHER	FATHER	CHILDREN	SIBLINGS
HEMORRHOIDS	☐	☐	☐	☐	☐
HEPATITIS	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐
HIGH CHOLESTEROL	☐	☐	☐	☐	☐
KIDNEY STONES	☐	☐	☐	☐	☐
MENINGITIS	☐	☐	☐	☐	☐
MIGRAINES	☐	☐	☐	☐	☐
NERVOUSNESS	☐	☐	☐	☐	☐
OSTEOPOROSIS	☐	☐	☐	☐	☐
PROSTATE DISEASE	☐	☐	☐	☐	☐
RHEUMATIC FEVER	☐	☐	☐	☐	☐
SEIZURES	☐	☐	☐	☐	☐
STOMACH ULCERS	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐
THYROID DISEASE: UNDER ACTIVE	☐	☐	☐	☐	☐
OVERACTIVE	☐	☐	☐	☐	☐

Vaccines: ***(Year of Last)***

Tetanus _____ Flu _____ Pneumonia _____ Other _____

Please list any surgeries you have had:_____

_____

_____

Please list any medications that you are currently taking:(Dosages & Times Per Day)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? No ☐ Yes ☐ (If Yes, please list)

_____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Do you smoke? No ☐ Yes ☐ **Did you ever smoke?** No ☐ Yes ☐ **If yes, when did you quit:** _____

Do you drink alcohol? No ☐ Yes ☐ How much? _____

Occupation: _____