Patient Information Form
Toheed J. Kamal, M.D., FRCP, FACP, FACE

Last Name First Name Middle Initial

Mailing Address Apt/Lot No.

City State Zip Code

Birth Date:___/___/____ Age: ____ Sex: ☐ Male ☐ Female

Marial Status: ☐ Single ☐Married ☐Divorced ☐Widowed

Social Security No. _____ Drivers License No. _____

Home No. ( ) _____ Cell No. ( ) _____

Employer: _____ Work No. ( ) _____

Email Address: _____

Insurance Carrier: _____

Policy Holder Name :_____Policy Holder Date of Birth: ____/____/_____

Policy No. _____ Group No._____

Emergency Contact Name/Relation: _____

Contact No. ( ) _____

RACE:	ETHNICITY:
American Indian or Alaska Native ☐	Hispanic or Latino ☐
Asian ☐	Not Hispanic or Latino ☐
Native Hawaiian or other Pacific Islander ☐	Refused to report ☐
Black or African American ☐	
White ☐	
Hispanic ☐	
Other Race ☐	
Unreported/Refused to Report ☐	

TURN OVER →

Reason for your visit: _____

_____

List any major medical illnesses

1._____ 4._____
2._____ 5._____
3._____ 6._____

Past surgeries and the year performed

1._____ 4._____
2._____ 5._____
3._____ 6._____

Date/Reason for major hospitalizations

1._____
2._____
3._____
4._____

Habits:

Do you exercise? Yes □ No □ Type/Amount _____
Do you use tobacco? Yes □ No □ Type/Amount _____
Do you use alcohol? Yes □ No □ Type/Amount _____
Do you use drugs? Yes □ No □ Type/Amount _____