PATIENT INFORMATION SHEET
M. SCOTT HAYDON, M.D., P.A.

Name:_____
(Last) (First) (Middle Initial)
S.S #:_____-_____-_____Date of Birth:_____Age:_____
Driver's License #:_____State:_____Sex: Female_____Male_____
Address:_____
City:_____State:_____Zip Code:_____
Home Ph:_____Work Ph:_____Cell Ph:_____
E-Mail Address:_____
Occupation:_____Employer:_____
Person to be contacted in case of an emergency:_____
Relationship to Patient:_____Phone Number:_____hm/wk/mobile_____
Phone Number:_____hm/wk/mobile_____
Reason for visit today: _____
Are you an emergency room referral?_____Date of Injury:_____
Hand Injuries: Hand Injured?_____Right or Left Handed?_____
Referring doctor or emergency room or other source:_____
Other family members seen by Dr. Haydon:_____

HEALTH INFORMATION

Height:_____Weight:_____General Doctor:_____
Current or past medical illnesses:_____
_____
_____
Previous Surgical Procedures:_____
_____
Significant Family Medical History:_____
_____
Current Medications you are taking:_____
_____
Allergies to Medication (What is your reaction):_____
_____
_____
Do you smoke? Yes/No If so, how often?_____
Do you drink alcohol? Yes/No If so, how often?_____

Female Patients:
Number of Pregnancies:_____Number of live births:_____
Date of Last Mammogram:_____Results: Normal:_____Abnormal:_____

INSURANCE INFORMATION

Please provide insurance card to be photocopied if necessary.
A referral from your primary care physician is required if you have HMO Insurance.