Jeff Alexander, M.D., P.C. 6565 South Yale, #503, Tulsa, OK 74136
Kelly Medical Building, (918) 494-8333 Fax: (918) 494-8334

Name _____ _____ I prefer to be called by this name: _____
Last First MI
Birthdate: _____ **Social Security Number** _____

Address _____ Apt #_____ City _____ State ___ ZIP _____

Email Address_____ **Home Phone**_____ **Cell Phone**_____
Would you like to receive correspondence via e-mail _____ ***Yes***_____ ***No***_____

Emergency Contact Name and Phone #_____

Marital Status: S, M, D, W **Spouse's name**: _____ (DOB)_____

Primary Care Physician_____ **Location**: _____ **Ph. Number** _____

Occupation _____**Employer** _____**Address**_____ **Work Phone** _____

Reason for visit**:** _____

The government requires the following questions as part of the law governing electronic health records

Tobacco Use: Smoke cigarettes: □ Never □ No □ Yes
(If you never smoked please go to alcohol use question now)

Quit date: _____ How many years did you smoke? _____ How many packs a day did you smoke? _____

Current smoker: Packs/day: _____ # of years: _____ **Other tobacco**: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use: Do you drink alcohol? □ No □ Yes How many drinks do you have per day? _____
Single Question Screening: How many times in the past year have you had 4 or more drinks in a day?_____

Advance Directive: □ None □ Do Not Resuscitate □ Durable Power of Attorney □ Living Will □ HC Proxy

Safety: Please circle I feel safe at home I do not feel safe at home

Please circle one: **American Indian Alaska Native Asian Black or African American**
Native Hawaiian or other Pacific Islander White/Caucasian Multi-Racial Hispanic or Latino
Other (*please specify)* _____
What is your preferred language? _____

Are you currently a client of: The Skin Care Institute Medical and Wellness Spa? _____

I further agree that all information submitted is true, correct and complete as of the date of my signature.

Signature_____**Date**_____