

Patient  
Name: \_\_\_\_\_

T. Michael McHenry, DDS, PA  
214 East Eau Gallie Blvd, Indian Harbour Beach, FL 32937



Date: \_\_/\_\_/\_\_

# MEDICAL INFORMATION

## Medical Doctor Information

Family Physician's Name: \_\_\_\_\_

Family Physician's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Family Physician's Phone: \_\_\_\_\_ Date of your last visit: \_\_\_\_\_

## Are you under the regular care of a specialist?

### Specialist #1

What specialty? \_\_\_\_\_

What are you being treated for? \_\_\_\_\_

Specialist's Name: \_\_\_\_\_

Specialist's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Specialist's Phone: \_\_\_\_\_ Date of your last visit: \_\_\_\_\_

### Specialist #2

What specialty? \_\_\_\_\_

What are you being treated for? \_\_\_\_\_

Specialist's Name: \_\_\_\_\_

Specialist's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Specialist's Phone: \_\_\_\_\_ Date of your last visit: \_\_\_\_\_

**Please list below any other medical professionals whose care you are currently under:**