David Grant, M.D.

303 E. Quincy, Suite 101

San Antonio, Texas 78215

210-227-1289

Today's Date_____

Name_____ ☐ **Male** ☐ **Female**

If Minor Name Of Guardian_____

Date Of Birth _____ **SSN#**_____-_____-_____ **ID/DL** _____

Address_____

City_____**State**_____**ZIP**_____

Home# (_____**)**_____**Wk#(**_____**)**_____ **Cell #(**_____**)**_____

E-mail: _____

REFERRED BY:_____

Are you allergic to any medications? _____No ____Yes

Please list and give type of reaction to the medication: _____

_____

**************************************PLEASE COMPLETE***********************************

Primary Care

Physician:_____

Address_____**Phone (**_____**)**_____

Person To Be Contacted In An Emergency Or If You Cannot Be Located:

(Preferably someone not living in same house)

Name_____**Phone(** ____**)**_____

Address_____**Phone #2 (**_____**)**_____

Relationship_____

Please note: Any controversy, claim or dispute that involves David Grant, MD or any independent provider associated with Sun Research Institute, L.L.C. shall be settled by mediation or arbitration in accordance with the rules of the American Arbitration Association, and judgement upon the award rendered by the arbitrators may be entered in any court have jurisdiction thereof.

_____ _____

Signature **Date**

NAME OF PATIENT_____

Current Medical Conditions And Start Dates. Include Any Allergies.

1. _____ **7.** _____

2. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

6. _____ **11.** _____

Surgeries and hospitalizations and dates if known:

1. _____ **6.** _____

2. _____ **7.** _____

3. _____ **8.** _____

4. _____ **9.** _____

5. _____ **10.** _____

Medications record:

(Include birth control pills, sleeping aids, vitamins, any OTC medications, etc)

Medication & dose	**Reason for taking**	**Date Started**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge that I have accurately and thoroughly completed this form.

_____ _____

Signature of Patient **Date**