Charles M. Mendenhall, M.D.
William J. McAfee, M.D.
D. Adam Jones, M.D.
Andrew T. Johns, P.A.-C.

Date: ______________ Date of Birth: _____ / _____ / ___________

Contact Information

Full Name: ____

Phone: ______________________ Email: ______________________________

Street Address: ____

City: ______________________ State: ____________________ Zip: __________

Insurance Company: ____

Primary Doctor: ____

Referring Doctor: ____

Adverse Food and/or Drug Allergies (Including Latex): ______________________________

____

Please bring medications and/or a complete list to your appointment.

Do you have a Georgia Advance Directive of Living Will? Yes No

Past Cancers and Cancer Treatments (Surgery, Chemotherapy and/or Radiation):

Cancer Treatment	Year

Family History of Cancer: ____

____

____

Tobacco Use: Yes No **Type:** ____________________ **Duration:** ____________________

Patient Signature: ______________________________ **Date/Time:** __________ __________

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