Confidential Patient Information

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

DATE:

WHO REFERRED YOU? _____

IS YOUR VISIT DUE TO AN ACCIDENT? ☐ YES ☐ NO (IF YES PLEASE COMPLETE BOTH SIDES)

PATIENT DATA **E-mail:_____**

NAME _____CELL PH (___)___ _-_____ HOME PH

ADDRESS _____CITY _____ STATE _____ ZIP _____

AGE _____ BIRTHDATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYED BY _____ DL # _____

WORK PH ( )_____-_____ ADDRESS_____

NAME OF WIFE OR HUSBAND _____ OCCUPATION _____

EMPLOYER _____ ADDRESS_____ PHONE # (___)____-_____

NAME OF NEAREST RELATIVE _____ PHONE # (___)_____-_____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS _____

_____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION _____

MEDICAL HISTORY (If any of the following are relevant to your medical history, please check the accompanying box.)

☐ CANCER	☐ HEADACHES	☐ **LOW BACK PAIN**	☐ **OSTEOPOROSIS**	☐ KNEE PROBLEM
☐ HIGH BLOOD PRESSURE	☐ DIZZINESS	☐ HEAD/NECK PAIN	☐ THYROID PROBLEM	☐ FRACTURE
☐ HEART ATTACK	☐ CONSTIPATION	☐ ARTHRITIS	☐ PROSTATE PROBLEM	☐ DISLOCATION
☐ STROKES	☐ CHRONIC INDIGESTION	☐ SHOULDER PROBLEM	☐ MOODINESS	☐ SPINAL SURGERY
☐ ABDOMINAL PAIN	☐ SINUS PRESSURE	☐ TUBERCULOSIS	☐ FEMALE PROBLEM	☐ SPRAIN/STRAIN INJURY
☐ DIABBETES	☐ ASTHMA	☐ RHEUMATIC FEVE	☐ MULTIPLE SCLEROSIS	☐ SCOLIOSIS
☐ FEELING OF WEAKNESS	☐ FULLNESS IN THE EAR	☐ HEPATITIS	☐ LUPUS	☐ OTHER-
☐ VISION PROBLEM	☐ PNEUMONIA	☐ RHEUMATISM	☐ CHICKENPOX	
☐ MEMORY /CONCENTRATION PROBLEM		☐ POLIO	☐ TRANSIENT ISCHEMIC ATTACKS	☐ AIDS

DESCRIBE THE OPERATIONS YOU'VE HAD: _____

_____WHEN?_____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? ☐ YES ☐ NO

DESCRIBE CONDITION _____DATE OF LAST PHYSICAL EXAM _____

ARE YOU ALLERGIC TO ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? _____

ARE YOU TAKING ANY MEDICATION? ☐ YES ☐ NO WHAT KIND? _____

ARE YOU PREGNANT? ☐ YES ☐ NO DATE OF LAST MENSTRUAL PERIOD _____

INSURANCE DATA (Clinic policy requires payment arrangements be made on the first visit.)

NAME OF PARTY RESPONSIBLE FOR PAYMENT _____PHONE (___)_____-_____

DO YOU HAVE INSURANCE? ☐ YES ☐ NO

PRIMARY INSURANCE _____

NAME OF INSURED _____

ID NUMBER _____

GROUP NUMBER _____

WORKER'S COMPENSATION _____

SECONDARY INSURANCE _____

NAME OF INSURED_____

ID NUMBER _____

GROUP NUMBER _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN'S SIGNATURE _____DATE_____

If yours is an accidental injury, please complete the reverse side of this form as well.