PATIENT INFORMATION

Name:____ Today's Date:__/__/__

Social Security Number [| |] [|] [| | |] Birth Date:___/___/___ Age:_____ Gender: F M

If you are under 18 years of age, who are your legal parents or guardians?

Father:____________________________________ Date of Birth:___/___/___ Phone: (___) ________________

Mother:____________________________________ Date of Birth:___/___/___ Phone: (___) ________________

Guardian:__________________________________ Date of Birth:___/___/___ Phone: (___) ________________

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of these

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Widowed How many children?________________

CURRENT ADDRESS

Street____

City____ State_________________ Zip____________

Phone (___) ____________________ Cell (___) _______________________ Email______________________________

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street____

City____ State_________________ Zip____________

Phone (___) _______________________

Your Occupation _________________________________ Employer ____

Work Address ____ Work Phone (___) ________________________

Student at ____ ☐ FULL-TIME ☐ PART-TIME

Name of Spouse ____ Spouse's Date of Birth ___/___/___

Spouse's Occupation ____ Spouse's Employer ______________________________

Spouse's Work Address ____ Work Phone (___) _______________

Spouse is a student at ____ ☐ FULL-TIME ☐ PART-TIME

Who should we contact in the event of an emergency? _____________________________ Phone (___) _________________________

Address of contact person ____

How did you learn about us? ____

Is your condition or injury due to an accident or work-related cause? ☐ YES ☐ NO Please check ALL that apply.

Did the condition or injury result from an automobile accident? ☐ YES ☐ NO

Did it result from a work-related accident of cause? ☐ YES ☐ NO (briefly describe): __________________________

____

If the condition did not result from an automobile accident or relate to your work, where did the accident occur?

____

Approximately, when did your injury or condition occur? ___/___/___

Describe your condition, symptoms, or the purpose of this appointment: ____

____

Have you ever had the same or a similar condition? ☐ YES ☐ NO If yes, when and describe:___________________________

____

--OVER--

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: ____________________________ Type of Practice: ________________________ Date of Last Visit: ___/___/___

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Date of last physical examination? ____

What operations have you had? ____ When? ____________________

Serious illness or conditions? ____ When? ____________________

Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO

Describe: ____

What medications or drugs are you taking? ____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐ Digestive Disorders
☐ Backaches	☐ Headaches	☐ Nervousness
☐ Heart Trouble	☐ Numbness	☐ Sinus Trouble
☐ Diabetes	☐ Asthma	☐ Anemia
☐ Hernia	☐ Neuritis	☐ Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐ YES ☐ NO ☐ UNCERTAIN

Do you have health insurance? ☐ YES ☐ NO Company: ____

Full name of Policy Holder: ________________________________ Policy Holder's Date of Birth: ___/___/___ Does the policy holder have the insurance through his/her employer? ☐ YES ☐ NO If yes, who is the employer? ___________________________

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – not between my insurance company and this office. I agree to pay my estimated copay at the time services are rendered, including any deductibles, and further understand that the estimated copay is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual copay as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owed on my account. I understand that an interest rate at the annual rate of 18% will appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all costs of such collection efforts, including, but not limited to, all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies or other payers which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: ____ Date: ___/___/___