

Case # _____

PATIENT INFORMATION

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WELCOME! Please allow us to make a copy of your photo ID and insurance cards.

PLEASE PRINT

Full Name _____ Gender **M** **F** Home Phone _____

Address _____ City _____ St _____ Zip _____

Age _____ Birthdate _____ Marital Status: Single Married Wid. Div. Sep. # of Children _____

SS# _____ E-mail _____

Your Employer _____ Occupation _____

Employer Address _____

Work Phone _____ Cell Phone _____

Do you have health insurance? Yes No Plan/Group# _____

Spouse/Parent/Guardian Name _____ Relationship _____

Employer _____ Occupation _____

Work Phone _____

Who is your medical doctor? _____

Is your present condition related to a: Work Injury Automobile Accident Liability Case

How did you find out about our office? _____

Payment options today (please indicate): Cash Check MasterCard Visa Discover N/A

Health History

Please check any items that apply to you:

| | | | | |
|-----------------|------------------|----------------------|----------------------|--------------------------|
| AIDS/HIV | Epilepsy | Infectious Disease | Osteoporosis | Females: |
| Allergy _____ | Fractures | Kidney Disease | Pacemaker | Pregnant Nursing |
| Arthritis | Gout | Liver Disease | Parkinson's Disease | Take Birth Control Pills |
| Asthma | Heart Disease | Lung Disease | Polio | |
| Blood Disorders | Hernia | Migraines | Rheumatoid Arthritis | |
| Cancer | Herniated Disc | Multiple Sclerosis | Stroke | |
| Diabetes | High Cholesterol | Neurological Disease | | |

Reason for visit today _____

Other health conditions: _____

Surgeries (with dates): _____

Current medications: _____

Daily Exercise: None Light Moderate Heavy
 Physical demands of work: Heavy Moderate Mild Sedentary
 Stress level of work: High Medium Low
 Do you use: Caffeine Tobacco Nicotine Recreational Drugs Alcohol
 Is there anything else we should know about you? _____

Authorization

I certify that I have read and understand the above information and answered all questions accurately to the best of my knowledge. I authorize this office to release any appropriate information during the course of my care including diagnosis and treatment records rendered to me (or my child) to third party payors and/or involved health practitioners. I authorize and request my insurance company to pay insurance benefits directly to this office for my care. I understand that if my insurance pays less than the actual bill for service, I agree to be personally responsible for payment of all services rendered on my behalf or my dependents. I understand that I am responsible for all co-payments and non-covered services. I agree that a photocopy of this agreement shall serve as the original.

X

Patient's Signature (or parent if minor)

Date