



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:

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

Reason for visit today _____

Have you had x-rays (MRI, etc.)? Where?: _____

Other health conditions or 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