## PATIENT INFORMATION

DATE: ______________________________ HOME PHONE: ______________________________

PATIENT NAME: ______________________________SOCIAL SECURITY #:______________________________

ADDRESS: ______________________________

CITY: ______________________________STATE:______________________________ZIP CODE:______________________________

SEX: _____M _____F BIRTHDATE: _____/_____/_______ _____SINGLE _____MARRIED _____SEPARATED _____DIVORCED

_____EMPLOYED _____FULL-TIME STUDENT _____PART-TIME STUDENT PATIENT'S SCHOOL NAME______________________________

PATIENT EMPLOYED BY: ______________________________ OCCUPATION:______________________________

BUSINESS ADDRESS:______________________________BUSINESS PHONE:______________________________

TYPE OF CASE: _____CASH _____PERSONAL HEALTH _____WORKMAN'S COMP. _____ AUTO ACCIDENT _____MEDICARE ______MEDICAID

REFERRED TO THIS OFFICE BY : ______________________________

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? ______________________________PHONE:______________________________

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## PRIMARY INSURANCE

RESPONSIBLE PARTY NAME:______________________________BIRTHDATE: _____/_____/_________

RELATIONSHIP TO PATIENT:______________________________ SOCIAL SECURITY #: ______________________________

ADDRESS (if different from patient):______________________________PHONE:______________________________

CITY:______________________________STATE:______________________________ZIP CODE:______________________________

RESPONSIBLE PARTY EMPLOYED BY:______________________________OCCUPATION:______________________________

BUSINESS ADDRESS:______________________________BUSINESS PHONE:______________________________

INSURANCE COMPANY:______________________________PHONE:______________________________

INSURANCE ADDRESS:______________________________

GROUP/POLICY #:______________________________SUBSCRIBER #:______________________________OTHER:______________________________

NAME(s) OF OTHER DEPENDENT (s) COVERED UNDER THIS PLAN:______________________________

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## ADDITIONAL INSURANCE

IS PATIENT COVERED BY ADDITIONAL INSURANCE?:_______YES _______NO

INSURED NAME:______________________________RELATIONSHIP TO PATIENT:______________________________BIRTHDATE:______________________________

ADDRESS (if different from patient):______________________________PHONE:______________________________

CITY:______________________________STATE:______________________________ZIP CODE:______________________________

RESPONSIBLE PARTY EMPLOYED BY:______________________________OCCUPATION:______________________________

BUSINESS ADDRESS:______________________________BUSINESS PHONE:______________________________

INSURANCE COMPANY:______________________________PHONE:______________________________

INSURANCE ADDRESS:______________________________

GROUP/POLICY #:______________________________SUBSCRIBER #:______________________________OTHER:______________________________

NAME(s) OF OTHER DEPENDENT (s) COVERED UNDER THIS PLAN:______________________________

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## ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to this clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________________________ ______________________________

Patient (or responsible party) Signature Relationship to Patient Date

## ABOUT YOUR CONDITION

WHAT IS YOUR CURRENT WEIGHT: _______LBS. HEIGHT:_______FT. _______IN.

PLEASE DESCRIBE YOUR CONDITION: Date Condition Began ____/____/________________________________________________________

____________________________________________________________________________________________________________

WHAT IS YOUR LEVEL OF PAIN TODAY? (scale of 1-10 ; 10 being severe):____________

IS THIS CONDITION GETTING WORSE? _____YES _____NO _______CONSTANT ______COMES & GOES

IS THIS CONDITION INTERFERING WITH YOUR (Please circle): WORK SLEEP DAILY ROUTINE

IF SO, PLEASE EXPLAIN: ____________________________________________________________________________________

HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? _____YES _____NO

IF SO, PLEASE EXPLAIN: ____________________________________________________________________________________

ARE YOU TAKING ANY OF THE FOLLOWING MEDICATIONS?

_____ NERVE PILLS _____ PAIN KILLERS (including aspirin)_____MUSCLE RELAXERS _____STIMULANTS _____BLOOD THINNERS

_____TRANQUILIZERS _____INSULIN _____OTHER(S)_____________________________________________________________

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITION(S) YOU HAVE OR EVER HAD: ____________________________________

PLEASE LIST ANYTHING THAT YOU MIGHT BE ALLERGIC TO: ______________________________________________________

LIST PREVIOUS SURGERIES (with dates):______________________________________________________________________

LIST ANY PAST SERIOUS ACCIDENTS (with dates):________________________________________________________________

SOCIAL HISTORY: DO YOU: DRINK ALCOHOL_____NO _____YES / HOW MUCH PER WEEK?______________________________

DO YOU: SMOKE _____YES _____NO EXERCISE_____YES_____NO WEAR SEATBELTS _____YES_____NO

FOR WOMEN: ARE YOU TAKING BIRTH CONTROL? _____ YES _____NO PAST PREGNANCIES______________________________

ARE YOU PREGNANT? _____NO YES / HOW LONG? ___________________ NURSING? _____YES _____NO

FAMILY HISTORY:

FATHER: DECEASED? _____NO: HEALTH PROBLEMS _______________ _____YES: CAUSE OF DEATH ______________________

MOTHER: DECEASED? _____NO: HEALTH PROBLEMS _______________ _____YES: CAUSE OF DEATH ______________________

BROTHERS/SISTERS: HOW MANY? _____ SIGNIFICANT HEALTH PROBLEMS_________________________________________

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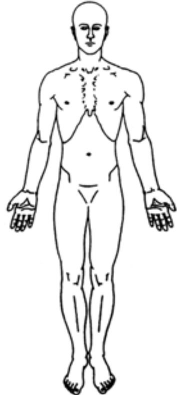
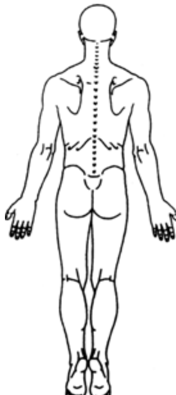
PLEASE MARK AREA(S) OF INJURY OR DISCOMFORT AS SHOWN BELOW IN THE KEY


FRONT

RIGHT


BACK

LEFT

| Key |
|---|
| Numbness * * * * |
| Pins & Needles o o o o |
| Burning ^ ^ ^ ^ |
| Aching x x x x |
| Stabbing • • • • |

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I authorize the staff to perform any necessary services needed during diagnosis and treatment. Furthermore, any risks involving treatment will be explained to me upon request. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

_____________________________________________ _____________________________

Patient (or responsible party) Signature Date