

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 _____

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

PATIENT DATA

WORK PHONE (____) _____

NAME _____ HOME PHONE (____) _____

CELL PHONE (____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYED BY _____ SS# _____

NAME OF NEAREST RELATIVE _____ PHONE NUMBER (____) _____

NAME OF WIFE OR HUSBAND _____ OCCUPATION _____

EMPLOYER _____ SS# _____ CLOCK OR EMPL.# _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS _____

LIST OTHER DOCTOR/S SEEN FOR THIS CONDITION _____

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

- | | | |
|--|---|--|
| <input type="checkbox"/> CANCER | <input type="checkbox"/> MUSCULAR DYSTROPHY | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> POLIO | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> TUBERCULOIS | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> NERVOUSNESS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> HEART TROUBLE | <input type="checkbox"/> CONCUSSION | <input type="checkbox"/> DIGESTIVE DISORDERS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> SINUS TROUBLE |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> BACKACHES |
| <input type="checkbox"/> GERMAN MEASLES | <input type="checkbox"/> NEURITIS | <input type="checkbox"/> NUMBNESS |
| <input type="checkbox"/> VENERAL DISEASE | <input type="checkbox"/> RHEUMATISM | <input type="checkbox"/> ANEMIA |

DESCRIBE THE OPERATIONS YOU HAVE 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 IF YES, 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 NO. (____) _____

DO YOU HAVE INSURANCE? YES NO COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE _____ EMPLOYEE I.D. NO. _____

SPOUSE'S INSURANCE _____ POLICY NO. _____

GROUP NO. _____

WORKER'S COMPENSATION _____ MEDICARE No. _____

OTHERS _____

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 _____