Confidential Patient Information

(IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST)

Today's Date: _______________
Name: ____ Date of Birth: ______________
(Last) (First) (mi.)
Address: ____
City: ___________________________________State: ________ Zip: ___________
Home Phone: _______________________Work Phone: _____________________
Age: _______ ❑ Male ❑ Female Marital Status: ❑ Married ❑Single ❑Divorced ❑Separated
Name of Spouse/Nearest Relative: _______________________________Phone: _________________
Your Occupation____________________________ Your Employer: ___________________________
Referred to this Office by: ❑Friend/Family Member - Name? ______________________________
❑ Mail ❑Clinic Location ❑Newspaper ❑Other________________________________
Payment for Services will be: ❑Cash ❑Check ❑Health Insurance
(At this time we are a provider for Anthem BCBS, Harvard Pilgrim & Cigna.)
Name of Insurance Co.: _________________________Insured's Social Security #: ________________
Insured's DOB: _____________________Plan ID #_____________________________________
Insured's Employer: ___________________Employer's Phone #: ________________
Are you covered by more than one insurance company? ❑Yes ❑No
If Yes, Name of other insurance company ____

Please provide insurance ID card to receptionist for verification.

MEDICAL/**FAMILY HISTORY (S = Self M = Mother F = Father)**

(Please indicate any past or current conditions)

S	M	F		S	M	F		S	M	F	
❑	❑	❑	dislocated joints	❑	❑	❑	neck pain	❑	❑	❑	rheumatic fever
❑	❑	❑	epilepsy	❑	❑	❑	back pain	❑	❑	❑	cancer
❑	❑	❑	arthritis	❑	❑	❑	numbness	❑	❑	❑	convulsions
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	PMS
❑	❑	❑	heart trouble	❑	❑	❑	poor circulation	❑	❑	❑	sinus troubles
❑	❑	❑	bladder trouble	❑	❑	❑	hepatitis	❑	❑	❑	diabetes
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	multiple sclerosis
❑	❑	❑	rheumatism	❑	❑	❑	concussion	❑	❑	❑	indigestion
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	muscular dystrophy

Have you been treated by a physician for any health condition in the last year?
❑Yes❑No if yes, please explain ____
____
Date of Last Physical Exam_____________________

SURGICAL HISTORY (Please list any past surgeries you have had and date of surgery.)
1. ____ Date: ______________
2. ____ Date:______________
3. ____ Date:______________
Have you ever had a metal implant? ❑Yes ❑No

ACCIDENT HISTORY (Please list any major accidents you may have had in the past.)
1. ____ Date: _____________
2. ____ Date: _____________
3. ____ Date: _____________

PRESENT MAJOR COMPLAINTS

Please rate your symptoms(1-10, with 1 being least serious)

Description Rating

1. ____

2. ____

Symptoms seem to be worse in the… ❑MORNING ❑AFTERNOON ❑NIGHT

When and *How* did you start to experience symptoms? ______________________
____
____

Date incident occurred? ____________________

How long have you been experiencing these symptoms? ______________________

Symptoms/complaints: ❑COME & GO ❑ARE CONSTANT

Have you ever had this before? ❑NO ❑YES When? ______________________

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION (S):
____

ARE YOU TAKING ANY MEDICATIONS? ❑NO ❑YES Name?______________________
____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION.

❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD ❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION.

❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN ❑TURNING HEAD ❑REACHING ❑WALKING

How much water do you drink daily? __________ Soda ____ Coffee____ Tea____

How much alcohol do you consume? ______________________

Do you or have you ever used tobacco? Yes No How much? ______________

Do you use recreational drugs? ______________________

Do you exercise regularly? ______________________

Disclaimer

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all moneys will be credited to my account upon receipt. I, also authorize the release of any health information necessary to process this claim. 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, the fees for professional services rendered me will be immediately due and payable. In the event of default I agree to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature (or legal guardian) ______________________ **Date:** __________