Confidential Patient Information

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

Today's Date: _____
Name: _____Date of Birth: _____
(Last) (First) (mi.)
Address:_____
City: _____State: _____ Zip: _____
Home Phone: _____Work Phone: _____
Age: ___ ❑ M ❑ F 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
Name of Insurance Co.: _____Insured's Social Security #: _____
Plan ID_____ Insured's DOB: _____
Insured's Employer: _____Employer's Phone #: _____
Are you covered by more than one insurance company? ❑Yes ❑No
If Yes, Name of other insurance company _____

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

What is your major complaint that brings you to our office today?

_____
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? _____

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:** _____