PATIENT INFORMATION FORM

Name: _____ Today's Date: ____/____/____

Social Security Number | | | | | | | | | | Birth Date: ____/____/____ Age: _____ Gender: F / M

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ____/____/____ Phone: (____) _____

Mother: _____ Date of Birth: ____/____/____ Phone: (____) _____

Guardian: _____ Date of Birth: ____/____/____ Phone: (____) _____

Who do you normally live with? ☐ Mother and Father ☐ Father ☐ Mother ☐ Legal Guardian ☐ None of These

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Single How many children? _____

CURRENT ADDRESS

Street _____

City _____ State _____ Zip _____

Phone (____) _____

OTHER ADDRESSES WHERE YOU RESIDE (e.g., parents' home, any other address where you regularly reside)

Street _____

City _____ State _____ Zip _____

Phone (____) _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone (____) _____

Student at _____ ☐FULL-TIME ☐PART-TIME

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ ☐FULL-TIME ☐PART-TIME

Who should we contact in the event of an emergency? _____ Phone (____) _____

Address of contact person _____

How did you learn about us? _____

Is your condition or injury due to an accident or work-related cause? ☐YES ☐NO Please check ALL that apply.

Did the condition or injury result from *automobile* accident ☐YES ☐NO

Did it result from *work-related* accident or cause? ☐ YES ☐ NO (briefly describe): _____

_____

If the condition did not result from an automobile accident or related to your work, where did the accident occur? _____

_____

Approximately, when did your injury occur? ____/____/____

Describe your condition, symptoms, or the purpose of this appointment: _____

_____

Have you ever had the same or similar condition? ☐YES ☐NO If yes, when and describe: _____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/____

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Date of last physical examination? _____

What operations have you had? _____ When? _____

Serious illnesses or conditions? _____ When? _____

Have you been treated for any health condition by a physician in the last year? ☐YES ☐NO

Describe: _____

Have you ever suffered from:

☐ Dizziness	☐ Arthritis	☐Digestive Disorders
☐ Backaches	☐Headaches	☐Nervousness
☐ Heart Trouble	☐ Numbness	☐Sinus Trouble
☐ Diabetes	☐Asthma	☐Anemia
☐ Hernia	☐ Neuritis	☐Cancer

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ☐YES ☐NO ☐ UNCERTAIN

Do you have Health Insurance? ☐ YES ☐ NO Company: _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth: ____/____/____ Do the policy holder have the insurance through his/her employer? ☐YES ☐NO If yes, who is the employer? _____

Policy Holders Social Security Number: _____

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I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself—not between my insurance company and this office. I agree to pay my estimated copay at the time services are rendered, including any deductibles, and further understand that the estimated copay is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual copay as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account. I understand that an interest charge at the annual rate of 18% will appear on all accounts over 90 days. I further understand and agree, that if this office must take action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office for all cost of such collection efforts, including, but not limited to , all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits to me, and to any attorneys who may be representing me due to my condition, and to complete any usual and customary reports and forms at no charge to assist in collecting from insurance companies, attorneys, or other payers.

I have read, understood, and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature: _____ Date: ____/____/____