Confidential Patient Data

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

PATIENT INFORMATION Today's Date:

Name: _____ Date of Birth:

Address: _____ City: _____ State Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Age: _____ Male: ☐ ☐ Female:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Other

Name of Spouse or Nearest Relative: _____ Phone: _____

Your Occupation _____Your Employer: _____

Referred to this Office by: ☐ Friend/Family Member – Name: _____

☐ Yellow Pages ☐ Mail ☐ Clinic Location ☐ Other

Payment for Services will be by: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance

☐ Automobile Insurance ☐ Worker's Compensation

Name of Insurance Co: _____ Insured's Employer _____

Insured's Social Security #: _____ Employer's Phone #: _____

Are you covered by more than one insurance company? ☐ Yes ☐ No Name _____

MEDICAL/FAMILY HISTORY S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	Dislocated joints	☐	☐	☐	Neck Pain
☐	☐	☐	Anaemia	☐	☐	☐	Epilepsy	☐	☐	☐	Nervousness
☐	☐	☐	Arthritis	☐	☐	☐	German measles	☐	☐	☐	Numbness
☐	☐	☐	Asthma	☐	☐	☐	Headaches	☐	☐	☐	Pollo
☐	☐	☐	Back pain	☐	☐	☐	Hearth trouble	☐	☐	☐	Poor circulation
☐	☐	☐	Bladder trouble	☐	☐	☐	Reproductive disorders	☐	☐	☐	Hepatitis
☐	☐	☐	Bone fracture	☐	☐	☐	High blood pressure	☐	☐	☐	Rheumatic fever
☐	☐	☐	Cancer	☐	☐	☐	HIV/ARC	☐	☐	☐	Rheumatism
☐	☐	☐	Chest pain	☐	☐	☐	Kidney disorder	☐	☐	☐	Scarlet fever
☐	☐	☐	Concussion	☐	☐	☐	Bowel control loss	☐	☐	☐	Serious injury
☐	☐	☐	Convulsions	☐	☐	☐	Menstrual cramps	☐	☐	☐	Sinus trouble
☐	☐	☐	Diabetes	☐	☐	☐	Multiple sclerosis	☐	☐	☐	Tuberculosis
☐	☐	☐	Indigestion	☐	☐	☐	Muscular dystrophy	☐	☐	☐	Venereal disease

Have you been treated by a physician for any health condition in the last year? Yes No

Describe Condition: _____ Date of Last Physician Exam: _____

SURGICAL HISTORY

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____

Have you ever had a metal implant? ☐ Yes ☐ No Ever been gunshot? ☐ Yes ☐ No

ACCIDENT HISTORY: ☐ Job ☐ Auto ☐ Other 1. _____ Date: _____

☐ Job ☐ Auto ☐ Other 1. _____ Date: _____

☐ Job ☐ Auto ☐ Other 1. _____ Date: _____

(Over please)