

**PATIENT INFORMATION**

**TODAY'S DATE** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_  
First MI Last

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number \_\_\_\_\_

Male     Female     Single     Married     Widowed

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**SPOUSE INFORMATION**

Name \_\_\_\_\_  
First MI Last

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**IF PATIENT IS A MINOR**

Father's Name \_\_\_\_\_  
First MI Last

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_  
First MI Last

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

**CONTACT INFORMATION**

For Emergency List Relative (not in same household) \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_  
City State Zip

Please name one person we may leave information with, in case of urgency? \_\_\_\_\_  
Name Phone #

Who may receive your health or financial information? \_\_\_\_\_  
Name

## MEDICAL HISTORY

Please fill out this brief medical history if this is your first visit in this office

What is the reason for your visit? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_  
(if physician please list address and office phone #)

Date Symptoms Noticed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Are you allergic to iodine? Yes  No  Are you allergic to shellfish? Yes  No

Are you allergic to latex? Yes  No

Do you have any allergies to medications? Yes  No  Please List: \_\_\_\_\_

Please list current medicines you are taking and dosage, if possible: \_\_\_\_\_

Have you taken aspirin or an anti-inflammatory medication lately? (do not include Tylenol) Yes  No

How frequently and how many do you take? \_\_\_\_\_

Please list approximate dates of your previous surgeries **which affect your current problem**: \_\_\_\_\_

Other surgeries? \_\_\_\_\_

Do you have diabetes? Yes  No  Heart disease? Yes  No

Lung disease? Yes  No  High blood pressure? Yes  No

Rheumatoid arthritis? Yes  No

Previous heart attack? Yes  No  When? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you had a stroke? Yes  No  When? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you had cancer? Yes  No  When? \_\_\_\_ / \_\_\_\_ / \_\_\_\_ What type? \_\_\_\_\_

Are you pregnant? Yes  No  How many pregnancies have you had? \_\_\_\_\_

Do you smoke? Yes  No  How many packs per day? \_\_\_\_\_ For how long? \_\_\_\_\_

How tall are you? \_\_\_\_\_ About what do you weigh? \_\_\_\_\_

## INSURANCE INFORMATION

(We require a copy of your insurance card(s) for our files)

### PRIMARY INSURANCE

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of policy holder \_\_\_\_\_  
First MI Last

Relationship to you  Self  Spouse  Child  Other (please specify) \_\_\_\_\_

### SECONDARY INSURANCE

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Group # \_\_\_\_\_ Policy # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of policy holder \_\_\_\_\_  
First MI Last

Relationship to you  Self  Spouse  Child  Other (please specify) \_\_\_\_\_

### INJURY RELATED

Is your condition related to any of the following:

Work Injury  Motor Vehicle Injury  Previous Surgery

Date of injury or surgery \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Description of injury or surgery \_\_\_\_\_

Adjuster's Name \_\_\_\_\_ Claim # \_\_\_\_\_

If legal proceedings are involved regarding any of the above, please list your attorney's name, address and telephone number:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

### FINANCIAL AGREEMENT

**I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits to the physician. I am aware that whether I am the patient, or the agent of the patient, I obligate myself to pay the physician in accordance with the regular rates and terms not covered by my insurance. All delinquent accounts bear interest at the legal rate. If legal action is required to collect fees for this service I agree to pay reasonable collection/ legal fees.**

Signature of Patient or Guardian \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_