

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: ____ / ____ / ____