



Patient Name: _____
(Last) (First) (Middle)

Social Security #: _____--____--_____ Date of Birth: ____/____/____

Street Address: _____ Apt.# _____

(City) (State) (Zip)
Please Circle: Male Female Marital Status (circle): M S D W Sep

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Primary Care Physician: _____
(Name) (Phone)

Person who referred you to our office: Physician Friend Family Other
Name: _____

INJURY/ACCIDENT RELATED TO WORK SCHOOL MOTOR VEHICLE OTHER
Date of Injury/Accident _____ Claim Number _____

Pharmacy: _____
(Name) (Phone) (Town)

Emergency Contact: _____
(Name) (Phone) (Relationship)

Employer Information: Name of Employer: _____

Address: _____
(Street) (City) (State) (Zip)

Occupation: _____ Work Phone: _____

Your Privacy Information:

Please List the family members, physicians who you currently see, or other persons, if any, whom we may inform about your medical condition and your diagnosis:

Can confidential messages be left on your telephone answering machine or voicemail: (circle one): Yes No

I have read and understand the notice of privacy practices _____
(Initial)

Appointment Policy:

If appointments are not cancelled 24 hours in advance, there will be a fee applied to your account.

MANAGED CARE PATIENTS ARE REQUIRED TO BRING A REFERRAL WHICH IS VALID BOTH BY DATE AND NUMBER OF VISITS.

Our Financial Policy:

Full payment may be due at time of service. We accept cash, checks, Visa, MasterCard, and Discover Card. The adult accompanying a minor and his/her parents (or guardian) are responsible for the bill. Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "Usual & Customary" Charges, Referrals, Etc., other than to supply factual information as necessary.

All payments should be made within 30 days of the patient receiving bills. If patient fails to make timely payments and this doctor needs to incur collection costs, counsel fees, and or other expenses, patient will be responsible to pay same. Payment plans can be arranged through our Billing Department. All balances over 90 days will be subject to a financial charge of 1.5% per month.

Please Sign that you have read the above information and that all information provided by you is correct.

Signature: _____ Date: ____/____/____

Please Print Name: _____

Patient Information

Patient Name: _____ Date of Birth: ___/___/___

What is reason for today's visit? Left Right

What Part of the body: _____

Pain: _____

How did the problem occur? _____

When/where did this happen? _____

Were X-rays, MRIs, or CT scans taken? **Yes** or **No** - if **YES** circle what scan(s)?

If Yes, Where? _____ and When? _____

Patient History

Height: _____ Weight: _____

Current Medications:

Allergies to Medications: _____

Past Medical History: (Please check all that apply)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Phlebitis in Legs |
| <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Ulcers/Stomach Disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Urinary Infection | <input type="checkbox"/> Dental Abscess | <input type="checkbox"/> Other |

Any Other Infection: _____

Any Other Illness: _____

Do you or have you ever smoked? Yes or No If Yes How Much? _____ How Long? _____

List All Past Surgeries _____

