Confidential Patient Information
Please Fill Out Completely

Last Name: _____First Name: _____Date: _____

Date of Birth: _____Age: _____SS#: _____Sex: ☐ M ☐ F

Address: _____City: _____ State/Zip: _____

Email: _____Home #: _____Cell #: _____

Occupation: _____Employer: _____Work #: _____

Employer Address: _____City: _____ State/Zip: _____

Marital Status: ☐ M ☐ S ☐ D ☐ W Spouse Name: _____Spouse DOB: _____

In Case of Emergency Contact: _____Relation: _____Phone #: _____

Who may we thank for referring you to this office? _____

Please describe the reason for your visit: _____

_____

How long have you had this condition? _____

Have you seen any other doctor/s for this condition? _____

Is your condition due to an injury or accident? ☐ Yes ☐ No Date of Injury: _____

Where did the accident occur? ☐ Work ☐ Auto ☐ Home ☐ Other_____

If this is an accidental or worker's compensation injury, please notify the receptionist immediately.

List any medical conditions you have: _____

Surgeries: ☐ Yes ☐ No Allergies: ☐ Yes ☐ No Prior Accidents: ☐ Yes ☐ No Medications: ☐ Yes ☐ No

If YES to any, please describe with dates: _____

Do you have a history of:

☐ **HEART DISEASE**	☐ **KIDNEY DISEASE**	☐ **HIGH BLOOD PRESSURE**	☐ **TUBERCULOSIS**	☐ **ULCERS**
☐ **CANCER**	☐ **GOUT**	☐ **PNEUMONIA**	☐ **LUNG DISEASE**	☐ **ASTHMA**
☐ **SKIN PROBLEMS**	☐ **HEPATITIS**	☐ **LIVER DISEASE**	☐ **THYROID DISEASE**	☐ **DIABETES**
☐ **EYE PROBLEMS**	☐ **LUPUS**	☐ **ARTHRITIS**	☐ **RHEUMATOID ARTHRITIS**	

OTHER_____

Health Insurance Information: **Do you have health Insurance ☐ Yes ☐ No**

Insurance Company Name:_____Policy Number: _____

Billing Address: _____City: _____ State/Zip: _____

Insurance Phone #: _____Group #: _____

Primary Insured: _____SS#: _____DOB: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am responsible for payment. I also understand that if I terminate my care and treatment, any fees for services rendered me will be due and payable immediately.

PATIENT'S OR GUARDIAN'S SIGNATURE_____**DATE**_____