Patient Information

Date _____

Please complete this form to the best of your ability. If you need help we will be glad to assist you!

Full Name_____ Address_____

City _____ State _____ Zip_____

Phone (Home)_____ Phone (Work) _____

Cell _____ E-mail _____

By giving your email you authorize us to use it for office contact and promotions. Email is not shared.

Sex: M F Single / Separated / Married /Partnered/ Widowed/ Divorced

Date of Birth _____ Social Security# _____

Employed / Student / Other Employer _____ Type of work_____

Emergency Contact _____ Phone_____ Relationship_____

Primary care M.D. _____

Insurance Information

Type of Insurance (circle): **Auto** **Health** **Medicare** **Work Injury** **Other**

Insurance company _____ Phone _____

Insured's Name _____ Insured's DOB _____

Auto only: Claim number_____ Adjuster's Name_____

Accident Injury Information

Are your present problems due to an accident-injury? Yes No Date of Accident _____

Type of accident-injury (circle): **Auto** **Work Injury** **Sports** **Military** **Household** **Slip/Fall** **Other**

Name of Attorney_____ Phone _____

Please indicate any of the following conditions that you have experienced past or present:

□AIDS □Alcoholism □Anemia □Anorexia □Appendicitis □Arthritis □Asthma □Bleeding Disorders □Breast Lump
□Bronchitis □Bulimia □Cancer □Cataracts □Chemical Dependant □Chicken Pox □Diabetes □Emphysema □Epilepsy
□Glaucoma □Goiter □Gonorrhea □Gout □Heart Disease □Hepatitis □Hernia □Herpes □High Cholesterol □HIV Positive
□Kidney Disease □Liver Disease □Measles □Migraine Headaches □Miscarriage □Mononeucleosis □Multiple Sclerosis
□Mumps □Pacemaker □Pneumonia □Polio □Prostate Problem □Psychiatric Care □Rheumatic Fever □Scarlet Fever
□Stroke □Suicide Attempt □Thyroid Problems □Tonsillitis □Tuberculosis □Typhoid Fever □Ulcers □Vaginal Infections
□Venereal Disease □Surgical Implants_____ □Surgery_____ □Other_____

Women Only: Is there a possibility you are pregnant? Y_____N_____