

WELCOME

PATIENT INFORMATION

Date _____
 SS/HIC/Patient ID # _____
 Patient Name _____
 Last Name _____
 First Name _____
 Middle Initial _____
 Address _____
 City _____ State _____ Zip _____
 E-mail _____
 Sex M F Age _____
 Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
 Occupation _____
 Patient Employer/School _____
 Employer/School Address _____
 Employer/School Phone (____) _____
 Spouse's Name _____
 Birthdate _____
 SS# _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____
 Cell Phone (____) _____
 Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
 Name _____
 Relationship _____
 Home Phone (____) _____
 Work Phone (____) _____

INSURANCE

Who is responsible for this account? _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 Is patient covered by additional insurance? Yes No
 Subscriber's Name _____
 Birthdate _____ SS# _____
 Relationship to Patient _____
 Insurance Co. _____
 Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
 Name of Insurance Company(ies)
 Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____
 Please print name of Patient, Parent, Guardian or Personal Representative _____
 Date _____ Relationship to Patient _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No
 Date _____
 Type of accident Auto Work Home Other
 To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other
 Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____
 When did your symptoms appear? _____
 Is this condition getting progressively worse? Yes No Unknown
 Mark an X on the picture where you continue to have pain, numbness, or tingling.
 Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)
 Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other
 How often do you have this pain? _____
 Is it constant or does it come and go? _____
 Does it interfere with your Work Sleep Daily Routine Recreation
 Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

