

# CONFIDENTIAL PATIENT INFORMATION

Date: \_\_\_\_\_ Full Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ email: \_\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_  
Street City State Zip  
Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Marital Status: M S W D\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pregnant? Yes No Unsure No. of Children: \_\_\_\_\_

Name of Spouse or Guardian: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer phone #: \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

Reason for appointment & related health problems:	Date started or for how long?	Have you had this before?	Injury related?
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1. _____	_____	yes no	yes no
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2. _____	_____	yes no	yes no
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Medical Doctors or Chiropractors you have seen in the past year:

Name: \_\_\_\_\_ Condition: \_\_\_\_\_

Name: \_\_\_\_\_ Condition: \_\_\_\_\_

Previous surgeries (please list all types):

1. Type: \_\_\_\_\_ Date: \_\_\_\_\_

2. Type: \_\_\_\_\_ Date: \_\_\_\_\_

3. Type: \_\_\_\_\_ Date: \_\_\_\_\_

Previous accidents or injuries (especially those that relate to your present problems):

1. Type: \_\_\_\_\_ Date: \_\_\_\_\_

2. Type: \_\_\_\_\_ Date: \_\_\_\_\_

3. Type: \_\_\_\_\_ Date: \_\_\_\_\_

# CONFIDENTIAL PATIENT INFORMATION (CONT.)

Current Medications: \_\_\_\_\_

Please circle the following conditions you may have had or have now:

Allergy	Alcoholism	Anemia	Arthritis
Backaches	Constipation	Convulsions	Cold Sores
Cancer	Diabetes	Sinus	Venereal Disease
Eczema	Gall Bladder	Heart Attack	High Blood Pressure
Stroke	Epilepsy	Measles	Blood Vessel Disease
Headaches	Heart Disease	Ulcers	Multiple Sclerosis
Neck Pain	Back Pain	Polio	Menstrual Cramps
Mumps	Diarrhea	Whooping Cough	Irregular Periods
Neuritis	Nervousness	Depression	Thyroid Problems
Gout	Pneumonia	Pleurisy	Low Blood Sugar
Malaria	Tuberculosis	Migraine	Miscarriage

Other: \_\_\_\_\_

## ASSIGNMENT & RELEASE

- I authorize release of information to family physicians and employers.
- I authorize release of information to insurance companies.
- I authorize the taking of photographs and x-rays to be used for treatment purposes.
- I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
- I authorize my insurance benefits to be paid directly to:

**Dr. Thomas Parkes**  
**231 Crosswicks Rd., Suite 1A**  
**Bordentown, NJ 08505**

**Patients Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PAYMENT POLICIES

1. PAYMENT FOR YOUR FIRST DAY'S SERVICES IS DUE AT THE COMPLETION OF YOUR OFFICE VISIT.
2. At the completion of your first office visit you will be advised as to a time you can return for your second consultation when the doctor will inform you as to your examination results and whether or not your case has been accepted. You will then also be advised concerning financial arrangements and insurance coverage as appropriate.

**I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.**

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_