

Welcome

Patient Information

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

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, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____ Date _____

Phone Numbers

Home _____ Work _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone _____

Work Phone _____ Ext _____

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

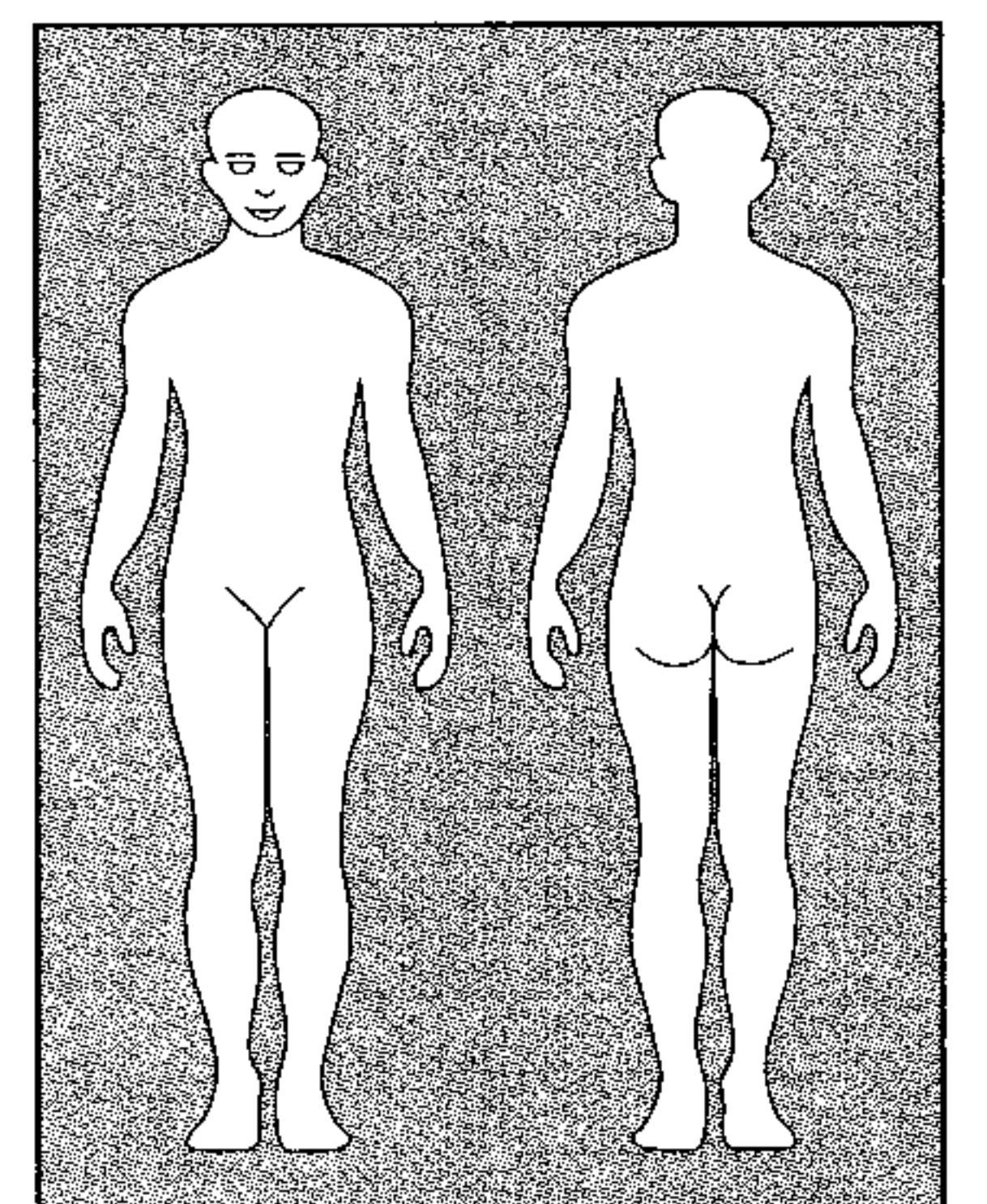
Shooting Burning Tingling Cramps Stiffness Swelling Other

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



MEDICAL HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | | | | | | |
|-----------------------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Anesthetics | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies to Medicine or Drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Foot or Leg Cramps | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angina | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Gout | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Artificial Heart Valves or Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swelling in Ankles, Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis or Jaundice | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bleeding Disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tired Feet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest Pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Varicose Veins | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chronic Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neuropathy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Phlebitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Ear Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

Surgeries you have had _____

Hospitalization other than for the surgeries listed _____

Family physician _____ Last visit date _____

Are you now, or have you been, under any other doctor's care for any reason over the past two years? Yes No

If yes, please explain _____

MEDICATIONS

Include prescriptions, over-the-counter medications and vitamins _____

Pharmacy Name(s) _____

Pharmacy Phone(s) (_____) _____

Do you take oral contraceptives? Yes No

ALLERGIES

Adhesive/Tape Local Anesthetics

Anticoagulant Therapy Novocaine

Aspirin Penicillin

Codeine Seafoods

Demerol Sulfa

Iodine

Other _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor (and the doctor's assistants or designated replacement) to administer and perform such procedures upon me as the doctor deems necessary.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient