

PATIENT INFORMATION

Date _____ 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

Preferred Language: English German Spanish
 Ethnicity: Hispanic/Latino Non-Hispanic/Latino Unreported
 Race: Am.Indian/Alaska Native Asian Black/Afr.American
 >1 Race Natv.Hawaiian Pac.Islander White Unreported

Occupation _____

Patient Employer _____

Do you have kids living at home? List Names & Ages

Spouse's Name _____

Whom my we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____ Subscriber Id # _____

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 my disclose such information to 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.

Signature of Patient, Parent, Guardian or Personal Representative

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

Date _____ Relationship to Patient

PHONE NUMBERS

Cell Phone (____) _____

Home Phone (____) _____

Work Phone (____) _____

Best time & place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Cell Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Type of accident Auto Work Home Other

Date of accident _____

Attorney Name (if applicable)

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting Worse Better About the same

Rate the severity of your pain on a scale from 1(least pain) to 10 (severe pain) _____

Type of pain Sharp Dull/Aching Throbbing Numbness/Tingling Shooting Burning

How often do you have this pain? (constant, come & go, etc.) _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

Mark an X on the picture everywhere you experience pain or symptoms.



