

Patient Information

Name (First, Middle, Last)

Responsible Party or Parents Name (if minor)

Gaur. BD

Address

City

State

Zip

Date of Birth

Age

Sex: M F

Social Security Number

Cell Phone

Home Phone

Email

Employer or Parent Occupation

Work Phone

RACE

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White

ETHNICITY

- Hispanic or Latino
- Not Hispanic or Latino

Preferred Language

Marital Status: S M D W

SPOUSE INFORMATION

Name

Employer

Work Phone

Cell

Email

.....

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT?

Name

Relationship

Address

City

State

Zip

Phone (Day)

Phone (Evening)

Cell

Email

REFERRING DOCTOR/SOURCE: _____

Information concerning your care provided by this center will be forwarded to your referring doctor/source unless otherwise specified

Insurance

Please present your insurance card to the receptionist.

PRIMARY INSURANCE CARRIER

Insurance Company Name

Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

Self Spouse Dependent

SECONDARY INSURANCE CARRIER

Insurance Company Name

Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

Self Spouse Dependent

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature

Date

Patient History

IS THIS A WORKERS COMP CLAIM: Yes No

Worker's Comp Billing Address _____

ALLERGIES: _____

Medicine

Other

PLEASE MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE OR HAVE HAD IN THE PAST:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney, bladder or prostate disease | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Muscle disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental health problems |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Nerve impairment | <input type="checkbox"/> Chronic skin disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer (past or present) | <input type="checkbox"/> Cervical spine disorder | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Hypoglycemia (low Glucose) | <input type="checkbox"/> Anemia or other blood disease | <input type="checkbox"/> Lumbar spine disorder | <input type="checkbox"/> Other |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Severe headaches | _____ |
| <input type="checkbox"/> Stomach disease | | <input type="checkbox"/> Tuberculosis/TB | _____ |

PAST MEDICAL CONDITIONS

Approx. Date Condition

Approx. Date Condition

Approx. Date Condition

Approx. Date Condition

CURRENT MEDICATIONS (Includes non-prescription products)

- | | | | |
|----------|----------|----------|----------|
| 1. _____ | 3. _____ | 5. _____ | 7. _____ |
| 2. _____ | 4. _____ | 6. _____ | 8. _____ |

PREFERRED PHARMACY _____

PERSONAL HABITS

Do you drink caffeinated beverages (coffee, tea, soda)? . . Yes No If yes, daily intake? _____

Do you drink alcoholic beverages Yes No If yes, _____ drinks per Day Week Month

Do you smoke or chew tobacco? Yes No If yes, _____ per day, _____ years of use

If no, any prior nicotine use? _____ years of use

ORTHOPEDIC OR OTHER MAJOR SURGERIES

Approx. Date Surgery

Approx. Date Surgery

Approx. Date Surgery

Approx. Date Surgery

Visit Information

Name (First, Middle, Last) Birthday Date

SPECIAL CONSIDERATIONS

- Legally blind
- Hearing impaired
- Pregnant
- Attempting Pregnancy
- Need handicap facilities
- None of the above.
- Smoker _____ Packs per day
- Substance abuse, describe: _____
- Alcohol abuse, describe: _____

WHAT WOULD YOU LIKE YOUR PHYSICIAN/TEAM TO ACCOMPLISH TODAY? (Mark all that apply)

- Accurate diagnosis
- Physical therapy
- Healthy exercise plan
- Other _____
- Nutritional plan
- Surgery plan if necessary
- Alternative therapy plan
(May include acupuncture, massage, manipulation)
- Medication/Injection
- Disability information

REASON FOR VISIT

REVIEW OF SYMPTOMS

	Do you have		If Yes, Explain
SKIN	Rashes, bumps, lumps, open sores, or wounds	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEAD EYES EARS NOSE THROAT	Failing eyesight, falls, seizures, vertigo, blackouts, hoarseness, or nasal congestion	<input type="checkbox"/> Yes <input type="checkbox"/> No
LUNGS	Unexpected breathlessness, wheezing (day or night), blood in sputum, or chronic cough	<input type="checkbox"/> Yes <input type="checkbox"/> No
HEART	Chest pain, irregular heart beat, or pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
BOWELS	Blood in stool, change in bowel habits, worrisome indigestion, or abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
BLADDER KIDNEY	Trouble urinating, infections, or blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
EMOTIONAL	Any mental health problems, depression, or suicidal tendency	<input type="checkbox"/> Yes <input type="checkbox"/> No
MUSCULOSKELETAL	Arthritis, fractures injuries, muscle weakness, or cramping	<input type="checkbox"/> Yes <input type="checkbox"/> No