

Patient Information

Name (First, Middle, Last)

Responsible Party or Parents Name (if minor)

Address

City State Zip

Date of Birth Age Sex: M F

Social Security Number

Cell Phone Home Phone

Email

Employer or Parent Occupation WorkPhone

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

D.O.B.

Cell Phone

Work Phone

Email

Pharmacy Preference _____ How Did You Hear About Us? () Google () Friend () Magazine () Other _____

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"/> Nerveimpairment | <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
 Smoker _____ Packs per day
 Hearing impaired
 Substance abuse, describe: _____
 Pregnant
 Alcohol abuse, describe: _____
 Attempting Pregnancy
 Need handicap facilities
 None of the above.

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
 Medication/Injection
 Disability information
 (May include acupuncture, massage, manipulation)

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