PATIENT INFORMATION

Date: _____
Patient Name:_____
Address:_____
City: _____ State: _____ Zip:_____
Email: _____
Sex: ☐ M ☐ F Age: _____ Birth Date:_____
☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Minor ☐ Partnered for _____ years
Occupation: _____
Patient Employer:_____
Spouse's Name: _____ Spouse's Employer: _____
Spouse's Birth Date (If souse is primary insurance member):_____
Whom may we thank you for referring you? _____
Or How did you hear about us:
__Web Search __Ad __Facebook __Twitter __Other Social Media __Other:_____

PHONE NUMBERS

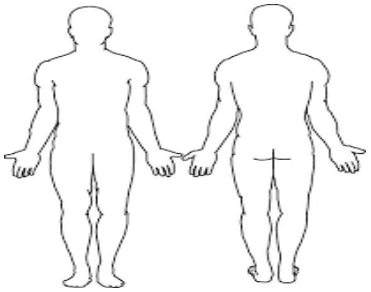
Patient Cell Phone: (_____)_____
IN CASE OF EMERGENCY CONTACT
Name: _____
Relationship: _____
Phone: (_____)_____

ACCIDENT INFORMATION

Is the 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

PATIENT CONDITION

Reason for Visit: _____
When did your symptoms occur? _____
Is this condition getting progressively worse? ☐Yes ☐No ☐Unknown



Mark an X on the picture where you have pain

Rate the severity of pain on a scale from 1 (least pain) to 10 (severe pain): _____
Type of pain: ☐Sharp ☐Dull ☐ Throbbing ☐Aching ☐Numbness ☐Shooting ☐Burning ☐Cramps
☐Tingling ☐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 ☐Laying down

INSURANCE

Who is responsible for this account? _____
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 certify that I, and/or my dependent(s), 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 authorize the use of my signature on all insurance submissions.

The above named doctor may use my healthcare 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. This consent will end when my current treatment plan is completed for one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient