WELCOME TO OUR OFFICE

TODAY'S DATE ___/___/___

1. PATIENT INFORMATION (PLEASE PRINT)

Name _____
First Last MI

Address _____

_____
City State Zip

Sex ☐M ☐F Date of Birth ___/___/___ Age_____

☐Single ☐Married ☐Widow ☐Separated ☐Divorced

SSN ☐☐☐-☐☐-☐☐☐☐

Occupation_____ ☐Full Time ☐Part Time

Employer_____

Employer Address_____

_____

Spouse's Name_____

Date of Birth ___/___/___ SSN_____

2. PHONE NUMBERS

H_____ W_____ Ext_____

Cell_____ ☐ Check box if OK to leave message on your cell or text you with HIPAA protected information.

E-mail_____

☐ Check box if OK to contact you via E-mail with HIPAA protected information.

Whom should we contact in case of emergency?

Name _____

Relationship _____

Cell Work

3. FINANCIAL INFORMATION

Are you the parent or legal guardian of the patient?

☐Yes Your Name_____

Relationship to Patient _____

Insurance Information: ☐None

Insurance Company _____

I.D. Number_____ Group_____

Phone Number _____

Subscriber's Name _____

Date of Birth _____ Relationship_____

Additional Insurance: ☐None

Insurance Company _____

I.D. Number_____ Group_____

Phone Number _____

Subscriber's Name _____

Date of Birth Relationship

4. ACCIDENT INFORMATION

Is your condition due to an accident? ☐ Yes ☐ No

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of this accident?

☐ Auto Insurnace ☐ Employer ☐ Work Comp ☐ Other

Attorney Phone

5. PATIENT CONDITION – YOUR MAIN COMPLAINT...

Reason for Today's Visit _____ Date Started ___/___/___

Do you know what may have caused this? _____

Is your PAIN / DISCOMFORT: ☐ Dull ☐ Sharp ☐ Burning ☐ Tingling ☐ Throbbing ☐ Numbness ☐ Stabbing

And is it? Mild Moderate Severe Pain Scale: MILD 1 2 3 4 5 6 7 8 9 10 SEVERE

How often do you suffer from this? ☐ Daily ☐ ___Times Per Week ☐ ___Times Per Month ☐ ___Times Per Year

How long does it last?_____ And Is It: ☐ Intermittent ☐ Frequent ☐ Constant

What makes it better?_____ What makes it worse?_____

Does it interfere with: ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Walking ☐ Bending ☐Standing ☐ Sitting

What have you tried to relieve your symptoms?