CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so that we can better serve you as a patient. Please fill in all portions of the form. If you need any help, Please ask the receptionist.

_____
DATE

IS YOUR VISIT DUE TO AN ACCIDENT? ❑ YES ❑ NO (IF YES, PLEASE COMPLETE BOTH SIDES) WORK PHONE (_____) _____

PATIENT DATA

NAME _____ HOME PHONE (_____) _____

CELL PHONE (_____) _____ PAGER # (_____) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SEX _____ BIRTHDATE _____ MARITAL STATUS _____ NUMBER OF CHILDREN _____

OCCUPATION _____ S.S.# _____ DRIVERS LIC.# _____

EMPLOYER _____ ADDRESS _____

NAME OF NEAREST RELATIVE _____ PHONE # (_____) _____

NAME OF WIFE OR HUSBAND _____ OCCUPATION _____ PHONE # (_____) _____

EMPLOYER _____ ADDRESS _____

PRESENT COMPLAINT

BRIEFLY DESCRIBE SYMPTOMS _____

_____

LIST OTHER DOCTORS SEEN FOR THIS CONDITION _____

MEDICAL HISTORY (If any of the following are relevant to your medical history, please check the accompanying box.)

- ❑ CANCER
- ❑ POLIO
- ❑ TUBERCULOSIS
- ❑ HIGH BLOOD PRESSURE
- ❑ HEART TROUBLE
- ❑ DIABETES
- ❑ HEPATITIS
- ❑ GERMAN MEASLES
- ❑ VENEREAL DISEASE
- ❑ MUSCULAR DYSTROPHY
- ❑ MULTIPLE SCLEROSIS
- ❑ CONVULSIONS
- ❑ EPILEPSY
- ❑ CONCUSSION
- ❑ DIZZINESS
- ❑ ARTHRITIS
- ❑ NEURITIS
- ❑ RHEUMATISM
- ❑ RHEUMATIC FEVER
- ❑ SCARLET FEVER
- ❑ NERVOUSNESS
- ❑ ASTHMA
- ❑ DIGESTIVE DISORDERS
- ❑ SINUS TROUBLE
- ❑ BACKACHES
- ❑ NUMBNESS
- ❑ ANEMIA

DESCRIBE THE OPERATIONS YOU'VE HAD _____ WHEN _____

HAVE YOU BEEN TREATED BY ANY PHYSICIAN FOR ANY HEALTH CONDITIONS IN THE LAST YEAR? ❑ YES ❑ NO _____

DESCRIBE CONDITION _____

ARE YOU ALLERGIC TO ANY MEDICATION? ❑ YES ❑ NO WHAT KIND? _____

ARE YOU TAKING ANY MEDICATION? ❑ YES ❑ NO WHAT KIND? _____

ARE YOU PREGNANT ❑ YES ❑ NO DATE OF LAST MENSTRUAL PERIOD _____

INSURANCE DATA (Clinic policy requires payment arrangements be made on first visit)

NAME OF PARTY RESPONSIBLE FOR PAYMENT _____ PHONE # (_____) _____

DO YOU HAVE INSURANCE? ❑ YES ❑ NO COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE

PATIENT'S INSURANCE _____

SPOUSE'S INSURANCE _____

WORKER"S COMPENSATION _____

OTHERS _____

AUTO INSURANCE _____

AGENTS NAME _____

AGENTS PHONE # _____

I understand and agree that health and accident insurance policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and terms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me will be immediately due and payable. I further agree to pay one and one half percent (1 1/2%) interest per month in case my account becomes thirty (30) days past due; until balance is satisfied. In the event I do not pay for services rendered and it becomes necessary to place my account with an attorney and/or collection agency, I oblige myself to pay attorney fees, court costs, agency fees, etc... In the amount of twenty-five percent (25%) in addition to the unpaid balance of my account.

PATIENTS SIGNATURE _____ DATE _____

SPOUSE'S OR GUARDIAN SIGNATURE _____ DATE _____

If yours is an accident injury, please complete the reverse side of this form as well.

ACCIDENTAL INJURY REPORT

If your clinic visit is due to an accident, please describe all events associated with it.

DATE OF ACCIDENT _____ HOUR OF ACCIDENT _____ AM PM

TYPE OF ACCIDENT ❑ WORK RELATED ❑ TRAFFIC ❑ OTHER

WORK RELATED ACCIDENT

EMPLOYER _____ TYPE OF BUSINESS _____

WAS ANY EQUIPMENT, MACHINERY AND/OR OBJECT RELATED TO ACCIDENT? WHAT KIND? _____

WAS ACCIDENT REPORTED TO SUPERVISOR AND/OR EMPLOYER? ❑ YES ❑ NO

HAS A WORKER COMPENSATION CLAIM BEEN FILED? ❑ YES ❑ NO

TRAFFIC ACCIDENT

WHAT KIND OF VEHICLE WAS INVOLVED IN ACCIDENT? ❑ TRUCK ❑ CAR ❑ MOTORCYCLE ❑ OTHER

WERE YOU A ❑ DRIVER ❑ PASSENGER ❑ PEDESTRIAN?

IF A PASSENGER, PLEASE INDICATE YOUR LOCATION IN THE VEHICLE _____

WAS YOUR VEHICLE MOVING WHEN THE ACCIDENT OCCURRED? ❑ YES ❑ NO

DID YOUR VEHICLE HIT OTHER VEHICLE(S) ❑ YES ❑ NO WHERE? _____

DID OTHER VEHICLE(S) HIT YOUR VEHICLE ❑ YES ❑ NO WHERE? _____

WAS ACCIDENT REPORTED TO POLICE DEPARTMENT? ❑ YES ❑ NO

WERE TRAFFIC CITATIONS ISSUED? ❑ YES ❑ NO TO WHOM? _____

DESCRIBE ACCIDENT INCLUDING CAUSE(S) AND SURROUNDING CIRCUMSTANCES _____

_____

_____

PRESENT COMPLAINT

- ❑ HEADACHE
- ❑ HEAD SEEMS TO HEAVY
- ❑ HEAD & SHOULDERS TIRED & HEAVY
- ❑ MENTAL DULLNESS
- ❑ LOSS OF MEMORY
- ❑ EQUILIBRIUM PROBLEMS
- ❑ DIZZINESS
- ❑ FAINTING
- ❑ TREMORS
- ❑ PALPITATION
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ NECK MOTION RESTRICTED
- ❑ UPPER BACK PAIN/STIFFNESS
- ❑ MID BACK PAIN/STIFFNESS
- ❑ LOW BACK PAIN/STIFFNESS
- ❑ PINS & NEEDLES IN ARMS/LEGS
- ❑ NUMBNESS IN FINGERS, ARMS, LEGS
- ❑ CHEST PAIN
- ❑ SHORTNESS OF BREATH
- ❑ EYE STRAIN
- ❑ PAIN BEHIND EYES
- ❑ EYES SENSITIVE TO LIGHT
- ❑ EYES-LOSS OF FOCUS
- ❑ DOUBLE VISION
- ❑ EARS-BUZZING/RINGING
- ❑ LOSS OF TASTE
- ❑ LOSS OF SMELL
- ❑ SINUS TROUBLE
- ❑ EXTREME NERVOUSNESS
- ❑ TENSION
- ❑ ANXIETY
- ❑ EXTREME FATIGUE
- ❑ INSOMNIA
- ❑ NEURITIS
- ❑ FACE FLUSHED
- ❑ FACE PALE
- ❑ EXCESS PERSPIRATION
- ❑ DIGESTIVE DISORDERS
- ❑ NAUSEA, VOMITING
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ DEPRESSION
- ❑ SWOLLEN _____
- ❑ FEET/HANDS COLD
- ❑ DIFFICULTY IN PROLONGED CAR RIDING

❑ DIFFICULTY IN EXCESSIVE ❑ STANDING ❑ WALKING ❑ RIDING ❑ BENDING

❑ NECK, LOW BACK PAIN & STIFFNESS UPON RISING

❑ PAIN RADIATING INTO ❑ RIGHT ARM ❑ RIGHT LEG ❑ BOTH ❑ LEFT ARM ❑ LEFT LEG ❑ BOTH

❑ DIFFICULTY IN EXCESSIVE LIFTING ❑ LIGHT ❑ MODERATE ❑ HEAVY ❑ REPETITIVE

❑ PAIN RADIATING INTO ❑ NECK ❑ BASE OF SKULL ❑ SHOULDER ❑ ARMS ❑ HIPS ❑ LEGS

DID YOU REQUIRE POST-ACCIDENT HOSPITALIZATION? ❑ YES ❑ NO IF SO, WHERE? _____

HAVE YOU HAD SIMILAR ACCIDENTS OR INJURIES BEFORE? ❑ YES ❑ NO

SYMPTOMS OTHER THAN ABOVE _____

_____

INSURANCE COMPANIES INVOLVED

INSURANCE COMPANY OF PARTY RESPONSIBLE FOR PAYMENT _____ CLAIM # _____

HAVE YOU BEEN CONTACTED BY AN INSURANCE ADJUSTER OR COMPANY REPRESENTATIVE ABOUT CLAIM? _____

HAS YOUR ATTORNEY ADVISED YOU IN THIS CASE? ❑ YES ❑ NO

ATTORNEY'S NAME - ADDRESS - TELEPHONE # _____

PATIENTS SIGNATURE _____ DATE _____