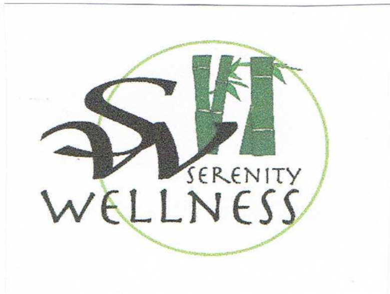

Today's Date: ________________

ABOUT YOU:

Patient Name: ____
What you prefer to be called: ______________________ ☐ Male ☐ Female
Birth Date: ________________ Age: ________ SS# ________________
Mailing Address: ____
____
Home Phone: __________________ Work Phone: ____________________
Mobile Phone: _________________ Email Address: _________________
Referred By: ____
Employer: ____
Employer's Address: ____
____
Occupation: ____
Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: ____
Do you have children? ☐ Yes ☐ No How many? __________

IN EVENT OF AN EMERGENCY:

Who should we contact?____
Relation: ______________ Phone Number: _________________________
Who is your Medical Doctor?____________________________________
Phone number: ______________ Office location: __________________

INSURANCE INFORMATION:

Company Name: ____
Address: ____
____
Phone Number: ________________ Insured's ID____________________
Group Number (Plan, Local, or Policy): __________________________
Insured's Name: ____

ACCOUNT INFORMATION:

Person ultimately responsible for account

Name: ____
Relation: ____
Billing Address: ____
____
Social Security Number: ____________ Driver's License Number: __________ State: ______
Phone Number ____________________

HEALTH HISTORY:

Are you taking any medications, including vitamins and over the counter? ☐ No If Yes, list below:

____

Do you have or have ever had any of the following diseases or conditions? Circle Yes or No

Y/N	Hear Attack	Y/N	Lower Back Problems	Y/N	Artificial valves
Y/N	Stroke	Y/N	Heart surgery	Y/N	Hepatitis
Y/N	Congenital Heart Defect	Y/N	Pacemaker	Y/N	Cancer
Y/N	Alcohol Abuse	Y/N	Mitral Valve Prolapse	Y/N	Anemia
Y/N	Drug Abuse	Y/N	STD/STI	Y/N	Ulcers/Colitis
Y/N	HIV+/AIDS	Y/N	Shingles	Y/N	Asthma
Y/N	Frequent Neck Pain	Y/N	Emphysema	Y/N	Chemotherapy
Y/N	High/Low Blood Pressure	Y/N	Glaucoma	Y/N	Arthritis
Y/N	Severe/Frequent Headaches	Y/N	Psychiatric Problems	Y/N	Heart Murmur
Y/N	Fainting	Y/N	Kidney Problems	Y/N	Tuberculosis
Y/N	Seizures	Y/N	Epilepsy	Y/N	Sinus Problems
Y/N	Difficulty Breathing	Y/N	Artificial Bones/Joints	Y/N	Diabetes

Please list any other serious medical condition you have or ever had: ____________________________

____

Please list anything that you may be allergic to: ____

List any previous surgeries/treatments with dates: _____________________________________

List any past serious accidents with dates: (Automobile, Worker's Comp, Slip and Fall, etc.)___________

____

FAMILY HEALTH HISTORY: (High blood pressure, Heart conditions, Diabetes, Cancer, etc.)_____________

____

Do you take vitamins or supplements? ☐ Yes ☐ No Exercise? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No SINCE: _______/_________/_________

Do you smoke? ☐ Yes ☐ NO Packs Per Day? ______ How Long?____________

Are you taking birth control? ☐ Yes ☐ NO Name:_________________________

Are you pregnant? ☐ YES ☐ NO / How far along? ___________ Nursing? ☐ YES ☐ NO

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understating between provider and patient.
- Our policy requires payment in full for services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collection your account.

- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. I authorize payment from any insurance carrier directly to this office with understanding that all will be credited to my account upon receipt. I clearly understand that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend my care and treatment, all fees for professional service rendered unto me would be immediately due and payable. .In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

SIGNATURE: ____ DATE:____/_____/______

☐ Patient ☐ Parent or Guardian ☐ Spouse