Welcome To Our Office

Patient Forms

MM DD YYYY

First Name: | Last Name: | Date Of Birth:

Home Phone: | Mobile Phone: | Work Phone:

@E-Mail: | Preferred Communication: (Circle) H M W E@

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

SSN: | Gender: ♀ Female ♂ Male | Preferred Language: ❑ English ❑ Other _____

Race & Ethnicity:

❑ American Indian or Alaska Native ❑ Hispanic or Latino
❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑ White ❑ Other

Marital Status:

❑ Single ❑ Married ❑ Other
❑ Divorced ❑ Widowed ❑ Separated

Emergency Contact Name: | Phone: | Relationship:

Primary Care Provider Name: | Phone:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Employer/Company Name: | Phone:

Street Address: | Apt/Suite #:

City: | ZipCode: | State:

Job Title/Position: | Currently Working: ❑ Yes ❑ No ⇨ Date Stopped Working:

Insurance Detail

Primary Insurance Coverage

Insurance Company Name:		Policyholder Name:
Insurance ID #:		Group Number:
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):		Payer ID:
Co-Pay $:	Co-Insurance %:	Deductible:

Secondary Insurance Coverage

Insurance Company Name:		Policyholder Name:
Insurance ID #:		Group Number:
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
(Office Use) Policy Effective Date(s):		Payer ID:
Co-Pay $:	Co-Insurance %:	Deductible:

Financially Responsible Party

❑ Self ❑ Other (If Other Please Complete Section Below)

First Name:	Last Name:	Date Of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@ E-Mail:	Relationship With Patient:	
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

Medical Detail

Reason For Your Visit

MM DD YYYY

☐ Wellness & Health Maintenance		
☐ Injury, Pain Complaint, or Ailment	Date Of Injury (When Did Your Pain Start?)	
☐ Accident ❑ Automobile Related Accident ❑ Other Type Of Accident	Date Of Accident: MM/DD/YYYY	State: Where Accident Occurred MM/DD/YYYY
Please Provide Brief Details Of Your Injuries & Pain:		

Referring Provider

❑ I Was Referred By My Primary Care Physician (Same Doctor Listed On First Page)

❑ I Was Referred By Another Doctor (Please Fill Out Doctor Info Below)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Representative Details (If You Are Being Represented By An Attorney For An Accident Please Provide Info)

Referring Provider Name:		Phone:
Street Address:	Apt/Suite #:	@ E-Mail:
City:	ZipCode:	State:

Medical History

MM DD YYYY

Lifestyle

Are You A Smoker? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Drink Alcohol? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week
Do You Exercise? ❑ Yes ❑ No	If Yes ➪ How Often? _____ /Day /Week

Have You Ever Been Hospitalized? ❑ Yes ❑ No	Have You Had Any Surgeries? ❑ Yes ❑ No
If Yes, Please List Dates/Details:	

Do You Have Any Allergies? ❑ Yes ❑ No ➪ Do You Require Medical Treatment For Your Allergies? ❑ Yes ❑ No

If Yes, Please Provide Details:

Do You Take Any Medications? ❑ Yes ❑ No

Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

_____ Patient Signature

_____ Date