

Welcome

PATIENT INFORMATION	INSURANCE
Date	Who is responsible for this account?
SS/HIC/Patient ID #	Relationship to Patient
	Insurance Co.
	Group #
Patient Name First Name M I	Is patient covered by additional insurance? Yes No
M. I.	Subscriber's Name
Address	BirthdateSS#
CityStateZip	Relationship to Patient
E-mail	Insurance Co
Sex M F AgeBirthdate	Group #
☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for	ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s), have insurance coverage with
Occupation	Name of Insurance Company(ies) and assign directly to
Patient Employer/School	Dr all insurance benefits, if
Employer/School Address	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.
Employer/School Phone ()	The above-named doctor may use my health care information and may disclose such 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
Spouse's Name	my current treatment plan is completed or one year from the date signed below.
Birthdate	Signature of Patient, Parent, Guardian or Personal Representative
SS#	
Spouse's Employer	Please print name of Patient, Parent, Guardian or Personal Representative
Whom may we thank for referring you?	Date Relationship to Patient
PHONE NUMBERS	ACCIDENT INFORMATION
Home Phone ()	Is condition due to an accident? Yes No
Cell Phone ()	Date
Best time and place to reach you	
IN CASE OF EMERGENCY, CONTACT Name	Type of accident Auto Work Home Other
Relationship	To whom have you made a report of your accident? ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other
Home Phone ()	Attorney Name (if applicable)
Work Phone ()	
PATIENT C	ONDITION
Reason for Visit	
When did your symptoms appear?	9 9
Is this condition getting progressively worse? Yes No Unknown	Wn A A
Mark an X on the picture where you continue to have pain, numbness, or t	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe Type of pain: Sharp Dull Throbbing Numbness Burning Tingling Cramps Stiffness	S Aching Shooting Swelling Other
	tant or does it come and go?
Activities of managements that are added to be produced in the	Corcuio.

Activities or movements that are painful to perform \square Sitting \square Standing \square Walking \square Bending \square Lying Down

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Cups/Day	syu	Cottee/Catteine Drinks			П Цдћі Гарог				VlisQ □
Drinks/Week			lorloolA 🗀		1	gnibnst≥ □	4		eteneboM [
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Olher	ON []	sey 🗌	Prosthesis	ON 🗆	Sey 🗆	Kidney Disease	ON	SØA 🗌	Vependency
Whooping Cough Yes N	ON	88À □	Prostate Problem	ON 🗆	SBY 🗌	losetselodo dgiH	1000 000		lealmen
Venereal Disease ☐ Yes ☐ N	ON	sex 🗆	Pollo	ON	seY 🗌	Herpes	ON	SOA 🗆	ancer
Vaginal Infections ☐ Yes ☐ N	ON	SeY [Pneumonia	ON 🗆	Sey 🗌	Hemisted Disk	ON	SOY -	ulimia
Ulcers ☐ Yes ☐ N	oN □	sey 🗌	Pinched Nerve	ON 🗆	seY 🗆	Hernia	ON 🗆	Sey 🗆	onchitis
Typhoid Fever ☐ Yes ☐ N	TI MO	eo. [7]	Parkinson's Disease	ON 🗆	SBY [Hepatitis		SOA [dmud tese
M ☐ vey ☐ Yes ☐ N		SBY [Pacemaker	oN 🗆	Sey 🗌	Heart Disease	914		arebrosi(
N □ Yes □ N		Sey [Osteoporosis	ON 🗆	SBY [Gout	oN 🗆	Sey 🗆	Bulpas
N □ seY □ stillianoT		SBY [Mumps	oN 🗆	SBY [Gonorhea	oN 🗆	Sey 🗌	smrtt
M □ seY □ ameldor9 biorynT	ON		Multiple Scierosis	oN 🗆	801	Golfer	ON 🗆	SOA 🗌	aitinti
Suicide Attempt		SOA [Mononucleosis	oN 🗆	SBY [Glaucoma	ON 🗆	SOY [pendicitis
Stroke Yes N	ON	SBA 🗆	Miscarriage	oN 🗆	SOA [Fractures	oN 🗆	Sel 🗌	огехів
Scarlet Fever Teves I Nes I N			Headaches	oN 🗆	SOY [Epilepsy	ON	sey 🗆	віта
Arthritis Rheumatic Fever \(\text{Yes} \) \(\text{A} \)	oN 🗆	seY 🗌	Migraine	ON 🗆	SƏ, 🗌	Emphysema	ON	SBY [ergy Shots
N □ seY □ biotemuerA	oN 🗆	SOY [selsseM	ON	Say [Diabetes	ON	59A 🗆	mailorio
Psychiatric Care	ON 🗆	seY 🗆	Liver Disease	ON [Say On a	cate it you have had Chicken Pox	ON []		OS/HIA
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		MRI, CT-Scan, Bone Scan				Pental X-Ray			
		Chest X-Ray				mex3 leniq2			
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HEALTH HISTORY