CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so 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 of Information

REFERRED BY WHOM? _____

IS YOUR VISIT TO THIS CLINIC IN REFERENCE TO AN ACCIDENT? ☐ YES ☐ NO (IF YES, PLEASE FILL IN BACK OF FORM.)

PATIENT DATA Email Address: _____ CELL PHONE: _____ WORK PHONE: _____

NAME _____ HOME PHONE: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ BIRTH DATE _____ MARITAL STATUS: _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYED BY _____ SS# _____

NAME OF NEAREST RELATIVE: _____ PHONE NO. _____

NAME OF WIFE OR HUSBAND _____ OCCUPATION _____ EMPLOYER _____

SS# _____ CLOCK OR EMPL.# _____

BRIEFLY DESCRIBE SYMPTOMS: _____

DATE OF LAST PHYSICAL EXAM: _____

WHAT OPERATIONS HAVE YOU HAD? _____

SERIOUS ILLNESSES: _____

LIST OTHER DOCTORS SEEN FOR THIS/THESE CONDITION(S). _____

_____

WHAT MEDICATIONS OR DRUGS ARE YOU TAKING? _____

INSURANCE DATA

Clinic policy requires payment arrangements be made on first visit.

NAME OF PERSONS RESPONSIBLE FOR PAYMENT _____ PHONE NO. _____

DO YOU HAVE INSURANCE? ☐ NO ☐ YES COMPANY _____

PLEASE LIST ALL SOURCES OF INSURANCE:

- GROUP INSURANCE _____ (Name)
- SPOUSE'S INSURANCE _____ (Name)
- WORKMAN'S COMPENSATION _____ (Name)
- OTHERS _____

EMPLOYEE I.D. NO. _____

POLICY NO. _____

GROUP NO. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms 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 on receipt. I permit this office to endorse co-issued remittances for the conveyence of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT'S SIGNATURE _____

If Yours Is An Accidental Injury, Please Complete The Information On The Reverse Side Also.