PATIENT INFORMATION

Date: _____/_____/_____

Last Name: ___________________________________ First: ___________________________ Middle: __________________

Sex: M _____ F _____ Date of Birth: _____/_____/______ Social Security #: _______________________________

Age: ______ Height: ______ Weight: ______ Marital Status: Married Single Widowed Divorced Other

Driver's Lic #: ________________________Home Ph: (_____)________________ Work Ph: (_____)_____________ext_____

Cell Ph: (_______) _________________________________ Cell Phone Carrier: ______________________________________

Email: ____

Patient Address: ____

City: ____ State: __________ Zip: ____________________________

Employed By: ____

Address: ____________________________________ City: __________________________ State: _____ Zip: ____________

Occupation: ____

Referred By: ____

Emergency Contact Name: ____ Ph: (_____)________________________

INSURANCE INFORMATION

Insured's Name: ____ Date of Birth: ___________________________

Address: ____

City: ____ State: ____________ Zip: ___________________________

Is insured employed and covered by employer's health plan? Yes No

Primary Insurance Name: ____

Policy or ID#: ____ Group #: _____________________________

Secondary Insurance Name: ____

Policy or ID#: ____ Group #: _____________________________

OTHER INFORMATION

What are your current specific problems? ____

____

Are you here as a result of an accident? Yes No Accident Date: _____/______/______

Accident Type: _____None _____Auto ______Work _____Home _____Recreation _____Sports _____Other

WORKERS' COMP CASE ONLY:

Employer Name and Address: ____

____

Supervisor: ____ Date: _____/_____/_____ Time: _______________

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: ________________________________ Date: ________________________________

Preferred Language?

_____ English

_____ Spanish

_____ Other______________________

Race?

_____ I do not wish to provide this information.

_____ White

_____ Black or African American

_____ American Indian or Alaska Native

_____ Asian

_____ Native Hawaiian or Other Pacific Islander

_____ Other______________________

Ethnicity?

_____ I do not wish to provide this information.

_____ Hispanic or Latino

_____ Non-Hispanic or Non-Latino

_____ Other______________________

Smoking Status?

_____ Current every day smoker

_____ Current some day smoker

_____ Former smoker

_____ Never smoker

Do you have any medication allergies?

_____ No known medication allergies

_____ Yes. What? ____________________________

____

Are you currently taking any medications?

_____ Not currently prescribed any medications

_____ Yes...

What? __________________________ Dose: _______ Form: _________ How Often: _______________

What? __________________________ Dose: _______ Form: _________ How Often: _______________

What? __________________________ Dose: _______ Form: _________ How Often: _______________

What? __________________________ Dose: _______ Form: _________ How Often: _______________

What? __________________________ Dose: _______ Form: _________ How Often: _______________