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

Lifestyle

MM DD YYYY

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