ANDOVER SPINE & HEALTH CENTER

Name					Social Security #
Address			City		Zip
Age	DOB	Marital Status M D S W	Sex M F	Ages of children	Cell Phone

Home Phone	Email
Occupation	Employer
Employer's address	Work Phone
Name of Spouse	Spouse's Cell Phone
Spouse's Occupation	Work Phone
Nearest Relative	Relative's Phone
Relative's Address Referred by	Is this condition due to injury or sickness arising out of employment? Yes No

Is this condition due to injury or sickness arising out of auto or other accident? Yes No	Days lost from work	Date symptoms appeared or accident happened

Purpose of this appointment?
Chief Complaints?

Other doctors seen for this condition; who and when?

Have you previously had the same or similar condition?
If yes, when and describe

Have you ever suffered from or been treated for any of the following?

❑ Allergies	❑ Numbness	❑ Arm Pain	❑ Stroke
❑ Asthma	❑ Bursitis/Pendonitis	❑ Difficulty Breathing	❑ Diabetes
❑ Dizziness	❑ Sinus Trouble	❑ Poor circulation	❑ Ulcers, Gastritis
❑ Fainting	❑ Ruptured Disc	❑ High Blood Pressure	❑ Digestive problems
❑ Loss of Sleep	❑ Arthritis	❑ Arteriosclerosis	❑ Urinary Problems
❑ Loss of weight	❑ Chest Pain	❑ Heart Trouble	❑ Menstrual Problems
❑ Sweats	❑ Cancer	❑ Neuritis	❑ Nervousness

Have you been treated for any health condition by a physician in the last year? Yes / No, Describe

What serious illnesses have you had and when?

List all surgeries you have had and when:

Name and facility of Primary Care Physician:

Health Insurance Yes / No	Name of Company	Member ID #
Insured Name on Card		Insured DOB
Secondary Insurance Company		Member ID #
Insured Name on Card		Insured DOB

I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care, as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself- not between my insurance company and this office. I authorize direct payment of medical benefits to this office and release of medical information necessary to process my insurance claims.
By signing this form, I acknowledge I received a copy of ASHC's Financial Policies and HIPAA Notice.

Patient's signature	Date
Guardian's Signature Authorizing Care	Date