Patient Information

Name (First, Middle, Last)

Responsible Party or Parents Name (if minor) Gaur. BD

Address

City State Zip

Sex: ☐ M ☐ F

Date of Birth Age

Social Security Number

Cell Phone Home Phone

Email

Employer or Parent Occupation Work Phone

Marital Status: ☐ S ☐ M ☐ D ☐ W

SPOUSE INFORMATION

Name

Employer

Work Phone

Cell

Email

RACE

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

ETHNICITY

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Preferred Language

IN CASE OF EMERGENCY WHO SHOULD WE CONTACT?

Name Relationship

Address City State Zip

Phone (Day) Phone (Evening) Cell Email

REFERRING DOCTOR/SOURCE:

Information concerning your care provided by this center will be forwarded to your referring doctor/source unless otherwise specified

Insurance

Please present your insurance card to the receptionist.

PRIMARY INSURANCE CARRIER

Insurance Company Name

Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Dependent

SECONDARY INSURANCE CARRIER

Insurance Company Name

Address

City State Zip

Phone Policy Number

Group Number / Name

Insured Name & DOB

Patient's relationship to insured:

☐ Self ☐ Spouse ☐ Dependent

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT OUR CHARGE FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I authorize the release of any medical information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and other agency reimbursements to this center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature Date

Patient History

IS THIS A WORKERS COMP CLAIM: ☐ Yes ☐ No

Worker's Comp Billing Address

ALLERGIES:

Medicine Other

PLEASE MAKE AN (X) BY ANY OF THESE CONDITIONS YOU MAY HAVE OR HAVE HAD IN THE PAST:

- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Lung disease
- ☐ Diabetes
- ☐ Hypoglycemia (low Glucose)
- ☐ Thyroid disease
- ☐ Stomach disease
- ☐ Kidney, bladder or prostate disease
- ☐ Joint replacement
- ☐ Liver disease
- ☐ Bowel disease
- ☐ Cancer (past or present)
- ☐ Anemia or other blood disease
- ☐ Blood clots
- ☐ Bleeding tendency
- ☐ Stroke
- ☐ Seizures
- ☐ Nerve impairment
- ☐ Cervical spine disorder
- ☐ Lumbar spine disorder
- ☐ Severe headaches
- ☐ Tuberculosis/TB
- ☐ Muscle disease
- ☐ Mental health problems
- ☐ Depression
- ☐ Chronic skin disease
- ☐ Sleep apnea
- ☐ Other

PAST MEDICAL CONDITIONS

Approx. Date Condition

Approx. Date Condition

Approx. Date Condition

Approx. Date Condition

CURRENT MEDICATIONS (Includes non-prescription products)

1. 2. 3. 4. 5. 6. 7. 8.

PREFERRED PHARMACY

PERSONAL HABITS

Do you drink caffeinated beverages (coffee, tea, soda)? . . ☐ Yes ☐ No If yes, daily intake?

Do you drink alcoholic beverages . . . . . ☐ Yes ☐ No If yes, _____ drinks per ☐ Day ☐ Week ☐ Month

Do you smoke or chew tobacco? . . . . . ☐ Yes ☐ No If yes, _____ per day, _____ years of use

If no, any prior nicotine use? _____ years of use

ORTHOPEDIC OR OTHER MAJOR SURGERIES

Approx. Date Surgery

Approx. Date Surgery

Approx. Date Surgery

Approx. Date Surgery

Visit Information

Name (First, Middle, Last) Birthday Date

SPECIAL CONSIDERATIONS

- ☐ Legally blind
- ☐ Hearing impaired
- ☐ Pregnant
- ☐ Attempting Pregnancy
- ☐ Need handicap facilities
- ☐ None of the above.
- ☐ Smoker _____ Packs per day
- ☐ Substance abuse, describe: _____
- ☐ Alcohol abuse, describe: _____

WHAT WOULD YOU LIKE YOUR PHYSICIAN/TEAM TO ACCOMPLISH TODAY? (Mark all that apply)

- ☐ Accurate diagnosis
- ☐ Nutritional plan
- ☐ Medication/Injection
- ☐ Physical therapy
- ☐ Surgery plan if necessary
- ☐ Disability information
- ☐ Healthy exercise plan
- ☐ Alternative therapy plan (May include acupuncture, massage, manipulation)
- ☐ Other

REASON FOR VISIT

REVIEW OF SYMPTOMS

	Do you have		If Yes, Explain
SKIN	Rashes, bumps, lumps, open sores, or wounds	☐ Yes ☐ No	
HEAD | EYES | EARS NOSE | THROAT	Failing eyesight, falls, seizures, vertigo, blackouts, hoarseness, or nasal congestion	☐ Yes ☐ No	
LUNGS	Unexpected breathlessness, wheezing (day or night), blood in sputum, or chronic cough	☐ Yes ☐ No	
HEART	Chest pain, irregular heart beat, or pacemaker	☐ Yes ☐ No	
BOWELS	Blood in stool, change in bowel habits, worrisome indigestion, or abdominal pain	☐ Yes ☐ No	
BLADDER | KIDNEY	Trouble urinating, infections, or blood in urine	☐ Yes ☐ No	
EMOTIONAL	Any mental health problems, depression, or suicidal tendency	☐ Yes ☐ No	
MUSCULOSKELETAL	Arthritis, fractures injuries,muscle weakness, or cramping	☐ Yes ☐ No	