Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. **PLEASE PRINT**.

Today's Date _____

Name _____ SS# _____

Address _____City _____ State _____Zip_____

Home Phone_____ Cell Phone _____Work Phone _____

Email_____

Age_____ Birthdate ____/____/_____ Marital Status: S M P W D No. Of Children _____

Describe the major complaints that bring you into our office _____

_____

Is your condition due to an accident? ☐ Yes ☐ No Date of Accident ____/____/_____

Type of accident ☐ Auto ☐ Work/On Job ☐ At Home ☐ Other

_____

Have you ever been in an Auto Accident? ☐ Past Year ☐ Past 5 years ☐ Over 5 years ☐ Never

Your Employer_____Occupation_____ Years on job _____

Employer Address _____City _____State _____Zip_____

Who is your primary health care physician? _____ Phone #_____

Do you have health insurance? ☐ Yes ☐ No Primary Insured: ☐ Self ☐ Spouse ☐ Parent

Insurance Co._____ Plan/Group # _____

Insured's Name_____ Relationship _____

Insured's Employer _____ Occupation_____ Years on job _____

Insured's work #_____ Birthdate ____/____/_____ SS#_____

I (we) agree to pay for services rendered to the above named patient as the charge is incurred. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non-covered. I also understand that if I suspend my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____Date _____

Spouse or Guardian's Signature _____Date _____