

**PATIENT INFORMATION FORM**

Name: _____ Today's Date: ____/____/____

Social Security Number Birth Date: ____/____/____ Age: ____ Gender: F M**CURRENT ADDRESS**

Street _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email: _____

Your Occupation _____ **Employer** _____Student at _____ FULL-TIME PART-TIME**Marital Status:** Married Separated Widowed Single **How many children?** _____

Name of Spouse _____ Spouse's Date of Birth ____/____/____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Work Address _____ Work Phone (____) _____

Spouse is a student at _____ FULL-TIME PART-TIME**Who should we contact in the event of an emergency?** _____ Phone (____) _____

Address of contact person _____

How did you learn about us? Referral Search Engine Yelp Walk-in/Drive by Print Advertisement Website

Other _____

If you are under 18 years of age, who are your legal parents or guardian?

Father: _____ Date of Birth: ____/____/____ Phone: (____) _____

Mother: _____ Date of Birth: ____/____/____ Phone: (____) _____

Guardian / Foster Parent: _____ Date of Birth: ____/____/____ Phone: (____) _____

Who do you normally live with (check all that apply)? Father Mother Guardian / Foster Parent Grandparent(s) Brother(s) / Sister(s) None of These

-- OVER --

Did the condition or injury result from **automobile accident**? YES NO

Did it result from a **work-related accident or cause**? YES NO (briefly describe): _____

If the condition did **NOT** result from an automobile accident or relate to your work, where did the accident occur? _____

Approximately, when did your injury or condition occur? ____/____/____

Describe your condition, symptoms, or the purpose of this appointment: _____

Have you ever had the same or similar condition? YES NO If yes, when and describe: _____

Please indicate any other healthcare providers who you've seen for THIS injury or condition, and when you last saw them.

Name: _____ Type of Practice: _____ Date of Last Visit: ____/____/____

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Date of last physical examination? _____

What operations have you had? _____ When? _____

_____ When? _____

_____ When? _____

Serious illnesses or conditions?

Type _____ Date _____ Type _____ Date _____

Type _____ Date _____ Type _____ Date _____

Have you been treated for any health condition by a physician in the last year? YES NO

Describe: _____

What medications or drugs are you taking? _____

Have you ever suffered from:

- Dizziness
- Backaches
- Heart Trouble
- Asthma
- Cancer
- Arthritis
- Headache/neck pain
- Numbness
- Anemia
- Other _____
- Digestive Disorders
- Nervousness
- Sinus Trouble
- Hernia (Disc)
- Loss of strength arms/legs
- Shortness of breath
- Diabetes
- Neuritis

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? YES NO UNCERTAIN

Do you have health insurance? YES NO Company: _____

Insurance ID Number: _____ Group Number _____

Full Name of Policy Holder: _____ Policy Holder's Date of Birth ____/____/____ Does the policy

holder have the insurance through his/her employer? YES NO If yes, who is the employer? _____

I have read, understood and agree to the foregoing. The information which I have provided is true and complete to the best of my knowledge

Patient's Signature: _____

Date: ____/____/____