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

**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? ____________________________

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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: ______/______/_______