CONFIDENTIAL PATIENT INFORMATION (PLEASE PRINT) CELL#:_____

NAME_____ ADDRESS_____ PHONE_____

CITY, ST_____ ZIP_____ AGE____ BIRTH DATE_____ MARITAL: M S W D

HOW MANY CHILDREN?____ OCCUPATION_____ EMPLOYER_____

ADDRESS_____ CITY, ST_____ ZIP_____ PHONE_____

PATIENTS NEAREST RELATIVE_____ADDRESS_____ PHONE_____

DATE OF LAST PHYSICAL?_____ WHAT OPERATIONS HAVE YOU HAD?_____

SERIOUS ILLNESSES?_____

PURPOSE OF THIS APPOINTMENT_____

OTHER DRS. SEEN FOR THIS CONDITION_____

DOES ANYONE ELSE IN YOUR FAMILY SUFFER FROM THIS OR SIMILAR CONDITION?_____

HAVE YOU EVER BEEN IN AN AUTOMOBILE ACCIDENT?_____ PLEASE GIVE DATE_____

HAVE YOU EVER BEEN INVOLVED IN ANY OTHER TYPE OF INJURY, FALL OR HAD A BROKEN BONE? PLEASE DESCRIBE BRIEFLY_____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR

DESCRIBE_____

PLEASE NAME ANY MEDICATION YOU ARE NOW TAKING_____

REMARKS AND ADDITIONAL INFORMATION_____

PAYMENT IS EXPECTED AT TIME OF VISIT!

NAME OF PERSON RESPONSIBLE FOR PAYMENT_____

DO YOU HAVE HEALTH INSURANCE?_____ COMPANY:_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE_____SS#:_____DATE_____

PARENT AUTHORIZING TREATMENT (IF MINOR)_____

WHO REFERRED YOU TO OUR CLINIC?_____

WEBSITE_____ PHONEBOOK_____ PPO/HMO_____