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 ____________ DATE ____________

PARENT AUTHORIZING TREATMENT (IF MINOR) ____________

WHO REFERRED YOU TO OUR CLINIC? ____________

WEBSITE ____________ PHONEBOOK ____________ PPO/HMO ____________