CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

How did you hear about our office?_____ **Is your visit due to an automobile or work related accident? Yes No**

PATIENT DATA

Social Security Number _____ Cell Phone Number _____

Last Name _____First_____MI_____ Home Phone Number _____

Address _____Apt.#_____City _____State _____ Zip_____

Age _____ Birthdate _____ Marital Status _____ Number of Children _____ Work Phone Number_____

Occupation_____ Employer _____ Address_____

Name of Nearest Relative _____ Relationship_____ Phone Number _____

Briefly Describe Symptoms_____

List Other Doctor/s Seen For This Condition _____

MEDICAL HISTORY *(If any of the following are relevant to **your** medical history, please check (✓) the condition)*

- ❑ Cancer
- ❑ Multiple Sclerosis
- ❑ Tuberculosis
- ❑ High Blood Pressure
- ❑ Heart Trouble
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Traumas
- ❑ Muscular Dystrophy
- ❑ Convulsions
- ❑ Concussion
- ❑ Dizziness
- ❑ Arthritis
- ❑ Rheumatism
- ❑ Venereal Disease
- ❑ Pacemaker
- ❑ Anemia
- ❑ Numbness
- ❑ Psychological Disorders
- ❑ Asthma
- ❑ Digestive Disorders
- ❑ Sinus Trouble
- ❑ Backaches
- ❑ Implants

Describe the Operations You Have Had: _____When? _____

Have you Been Treated By A Physician For Any Health Condition In The Last Year? Yes No

Describe Condition _____Date of Last Physical Exam _____

Are You Taking Any Medication? Yes No What Kind? _____

Are You Pregnant? Yes No Date Of Last Menstrual Period _____

INSURANCE DATA

Do You Have Insurance? Yes No Does **Your** Name Appear On Your Insurance Card? Yes No

If No, Name of Party Responsible For Insurance Payment If Other Than You _____ Date Of Birth_____

Phone Number _____ SSN _____ Relationship _____

Please List All Sources Of Insurance

Patient's Insurance _____ Employee ID # _____

Spouse's Insurance _____ Group or Policy # _____

Patient Signature: _____ Date: _____

Where your health comes first — Donde su salud es lo primero