ATLANTIC COAST MEDICAL CARE, L.L.C.

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Confidential Patient Data

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION

Today's Date:_____

Name:_____**Date of Birth**:_____

Address:_____ **City**:_____ **State**:_____**Zip**:_____

Home Phone:_____**Work Phone**: _____ **Cell Phone**: _____
Email: _____ **Social Security #**:_____ **Age**:____
❑**Male** ❑**Female** **Marital Status**:❑Married ❑Single ❑Divorced ❑Separated ❑Other _____
Name of Spouse or Nearest Relative:_____ **Phone**:_____
Your Occupation_____ **Your Employer**:_____
Referred to this Office by: ❑Friend/Family Member ❑Internet ❑ Mail ❑Yellow Pages
Payment for Services will be by: ❑Cash ❑Check ❑Credit Card ❑Health Insurance
❑Automobile Insurance ❑Worker's Compensation
Name of Insurance Co.:_____**Insured's Employer**:_____
Insured's Social Security #:_____ **Employer's Phone #**:_____
Are you covered by more than one insurance company? ❑Yes ❑No Name _____

MEDICAL/FAMILY HISTORY

S = Self M = Mother F = Father

(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
❑	❑	❑	AIDS	❑	❑	❑	dislocated joints	❑	❑	❑	neck pain
❑	❑	❑	anemia	❑	❑	❑	epilepsy	❑	❑	❑	nervousness
❑	❑	❑	arthritis	❑	❑	❑	German measles	❑	❑	❑	numbness
❑	❑	❑	asthma	❑	❑	❑	headaches	❑	❑	❑	polio
❑	❑	❑	back pain	❑	❑	❑	heart trouble	❑	❑	❑	poor circulation
❑	❑	❑	bladder trouble	❑	❑	❑	reproductive disorders	❑	❑	❑	hepatitis
❑	❑	❑	bone fracture	❑	❑	❑	high blood pressure	❑	❑	❑	rheumatic fever
❑	❑	❑	cancer	❑	❑	❑	HIV/ARC	❑	❑	❑	rheumatism
❑	❑	❑	chest pain	❑	❑	❑	kidney disorder	❑	❑	❑	scarlet fever
❑	❑	❑	concussion	❑	❑	❑	bowel control loss	❑	❑	❑	serious injury
❑	❑	❑	convulsions	❑	❑	❑	menstrual cramps	❑	❑	❑	sinus trouble
❑	❑	❑	diabetes	❑	❑	❑	multiple sclerosis	❑	❑	❑	tuberculosis
❑	❑	❑	indigestion	❑	❑	❑	muscular dystrophy	❑	❑	❑	venereal disease

Have you been treated by a physician for any health condition in the last year? ❑Yes ❑No

Describe Condition_____ Date of Last Physical Exam_____

SURGICAL HISTORY:

1._____ Date:_____
2._____ Date:_____
3._____ Date:_____
4._____ Date:_____
5._____ Date:_____

Have you ever had a metal implant? ❑Yes ❑No Ever been gunshot? ❑Yes ❑No

ACCIDENT HISTORY: ❑Job ❑Auto ❑Other 1. _____ Date:_____
❑Job ❑Auto ❑Other 2._____ Date:_____
❑Job ❑Auto ❑Other 3._____ Date:_____

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1._____

2._____

3._____

4._____

5._____

6._____

SYMPTOMS ARE WORSE IN ❑MORNING ❑AFTERNOON ❑NIGHT

WHEN AND HOW OCCURRED?_____

_____

SYMPTOMS DEVELOPED FROM: ❑JOB RELATED INJURY ❑AUTO ACCIDENT ❑OTHER ❑ACCIDENT ❑ILLNESS ❑UNKNOWN CAUSE ❑GRADUAL ONSET DATE OCCURRED:_____

SYMPTOMS HAVE PERSISTED FOR # ____HOUR(S) ____DAY(S) __WEEK(S) ___MONTH(S) ___YEAR(S)

SYMPTOMS/COMPLAINTS: ❑COME & GO ❑ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ❑NO ❑YES WHEN?_____

IF YOU WERE TO GUESS, WHAT DO YOU THINK IS CAUSING YOUR COMPLAINTS?

_____ _____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____

ARE YOU TAKING ANY MEDICATIONS ❑NO ❑YES WHAT KIND?_____

_____

ARE YOU PREGNANT ❑NO ❑YES DATE OF LAST MENSTRUAL PERIOD_____

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
❑BENDING ❑REACHING ❑STRAINING AT STOOL ❑COUGHING ❑SITTING ❑TURNING HEAD
❑LIFTING ❑SNEEZING ❑WALKING ❑LYING DOWN ❑STANDING

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
❑BENDING ❑SITTING ❑LIFTING ❑STANDING ❑LYING DOWN
❑TURNING HEAD ❑REACHING ❑WALKING

PLEASE CHECK ANY **ADDITIONAL SYMPTOMS** YOU MAY BE EXPERIENCING:
❑blurred vision ❑buzzing in ears ❑cold feet ❑cold hands ❑cold sweats ❑concentration loss /confusion ❑constipation ❑depression /weeping spells ❑diarrhea ❑dizziness ❑face flushed ❑fainting ❑fatigue ❑fever ❑head seems too heavy ❑headaches ❑insomnia ❑light bothers eyes ❑loss of balance ❑loss of smell ❑loss of taste ❑low resistance to colds ❑muscle jerking ❑numbness in fingers ❑numbness in toes ❑pins and needles in arms ❑pins and needles in legs ❑ringing in ears ❑shortness of breath ❑stiff neck ❑stomach upset

Patient's Signature:_____

Date:_____