PATIENT INFORMATION

FILE NUMBER: _____ DOCTOR: _____

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE #: (____) ____-_____ CELL PHONE #: (____) ____-_____

E-MAIL: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (____) ____-_____

SOCIAL SECURITY#: _____ D.L. OR I.D# _____

OCCUPATION: _____ NAME OF EMPLOYER: _____

WORK PHONE #: (____) ____-_____ WORK ADDRESS: _____

WHAT TYPE OF INJURY IS THIS: FALL/WORK RELATED/AUTO, OTHER: _____

INSURANCE INFORMATION

HEALTH INSURANCE:

NAME OF INSURED: _____ RELATION WITH THE PATIENT: _____

NAME OF INSURANCE COMPANY: _____ POLICY: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

YOUR AUTO INSURANCE:

NAME OF INSURANCE COMPANY: _____ POLICY: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

THE OTHER PERSON'S INSURANCE INFORMATION:

NAME OF THE INSURED: _____ POLICE REPORT: YES / NO

NAME OF INSURANCE COMPANY: _____ POLICY: _____

ATTORNEY INFORMATION

NAME OF LAWYER: _____ PHONE: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (____) ____-_____

WHAT IS YOUR MAYOR COMPLAINT: _____

- CIRCLE WHAT APPLIES TO YOU: SINCE THE ACCIDENT, THE SYMPTOMS: A: GET BETTER B: GET WORSE C: NO CHANGE D: COME AND GO. THE FIRST SYMPTOM OCCUR: _____
- ACTIVITIES THAT WHICH AGGRAVATE YOUR CONDITION: A: STANDING B: WALKING C: SITTING D: LYING E: BENDING F: LIFTING G:TWISTING H:COUGHING.
- HAVE YOU HAD THESE SYMPTOMS BEFORE? _____ IF YES, WHEN? _____
- HAVE YOU BEEN INVOLVED IN OTHER ACCIDENTS, HAD FRACTURES OR OTHER CONDITION? YES / NO
  WHEN: _____DESCRIBE: _____
- HAVE YOU SEEN ANOTHER DOCTOR FOR THIS CONDITION (THIS ACCIDENT)? YES / NO
  NAME OF DOCTOR OR HOSPITAL: _____ WHEN? _____ X-RAYS? _____
- DIAGNOSTIC: _____FRACTURES? YES / NO WHERE?_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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.

_____ _____

PATIENT'S SIGNATURE DATE