Frontier Integrated Health Center, Inc
2011 Hwy K
O'Fallon, MO 63366
Dr. R. James Ottomeyer III

New Patient Information
AUTOMOBILE ACCIDENT

PERSONAL INFORMATION Date _____

Last Name:_____ First Name:_____M.I.:_____

Street:_____ Email Address:_____

City:_____ State:_____Zip Code:_____

Home Phone:_____ Cell Phone:_____

Social Security Number:_____ Birth Date:_____ Current Age:_____

Race: _____ Preferred Language:_____ Ethnicity:_____

Sex: ☐ Male ☐ Female Student Status: ☐ Non ☐ Full time ☐ Part time

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Number of Children:_____

Mother Maiden Name: First Name _____ Last Name _____

Emergency Contact Name: _____ Phone: _____ Relation_____

Occupation:_____ Employment Status: ☐ Full time ☐ Part time

Employer Name:_____ Work Phone:_____

Employer Street:_____ City:_____ State:_____ Zip Code_____

Spouse Name:_____Employer:_____Work Ph:_____

Medical Physician's Name: _____Previous Chiropractor's Name:_____

HOW DID YOU HEAR ABOUT FRONTIER INTEGRATED HEALTH CENTER

Referred By:_____

☐ Family ☐ Friend ☐ Co Worker ☐ Attorney ☐ Yellow Pages ☐ Mail Coupon

☐Newspaper ☐Direct Mailer ☐Friend of Doctor ☐Street Sign ☐ Other:_____

INSURANCE INFORMATION

Insured:_____ Insurance Company:_____

Patients Relationship To Primary Insured: ☐ Self ☐Spouse ☐ Child ☐ Other:_____

IF YOUR SYMPTOMS ARE DUE TO AN AUTO ACCIDENT OR WORK INJURY PLEASE STOP AND NOTIFY OUR STAFF

CURRENT HISTORY/TREATMENT (Please be brief)

Present Complaint:_____

This Condition Is Due To: _____

Date Symptoms Appeared/Accident Occurred:_____ ☐ Gradual ☐Sudden

Have You Had Similar Symptoms Previous To This Incident? ☐ Yes ☐ No Date:_____

Have You Been Unable To Work Due To This Incident? ☐ Yes ☐ No Dates Missed Work From:_____ To:_____

Have You Been Hospitalized Due To This Incident? ☐ Yes ☐ No Place/Dates:_____

Have You Had X-Rays Taken Due To This Incident? ☐ Yes ☐ No Place/Date:_____ __Results:_____

Is this condition getting progressively worse or better? Select One

CURRENT HISTORY/TREATMENT (CONT): **Name:** _____

Which daily activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down ❑Other (please describe)

_____

PREVIOUS HISTORY/TREATMENT

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Chiropractic Care ❑ Physical Therapy ❑ Other_____

GENERAL HEALTH HISTORY *check only those conditions which are applicable:*

❑ AIDS/HIV	❑ Cataracts	❑ Hepatitis	❑ Osteoporosis	❑ Suicide Attempt
❑ Alcoholism	❑ Chemical Dependency	❑ Hernia	❑ Pacemaker	❑ Thyroid Problems
❑ Allergy Shots	❑ Chicken Pox	❑ Herniated Disc	❑ Parkinson's Disease	❑ Tonsillitis
❑ Anemia	❑ Depression	❑ Herpes	❑ Pinched Nerve	❑ Tuberculosis
❑ Anorexia	❑ Diabetes	❑ High Cholesterol	❑ Pneumonia	❑ Tumors, Growths
❑ Appendicitis	❑ Emphysema	❑ Hypertension	❑ Polio	❑ Typhoid Fever
❑ Arthritis	❑ Epilepsy	❑ Liver/Kidney Disease	❑ Prostate Problems	❑ Ulcers
❑ Asthma	❑ Fractures	❑ Measles	❑ Prosthesis	❑ Vaginal Infections
❑ Bleeding Disorders	❑ Glaucoma	❑ Migraine Headaches	❑ Psychiatric Care	❑ Venereal Disease
❑ Breast Lump	❑ Goiter	❑ Miscarriage	❑ Rheumatoid Arthritis	❑ Whooping Cough
❑ Bronchitis	❑ Gonorrhea	❑ Mononucleosis	❑ Rheumatic Fever	❑ Stroke
❑ Bulimia	❑ Gout	❑ Multiple Sclerosis	❑ Scarlet Fever	❑ Mumps
❑ Cancer	❑ Heart Disease	❑ Other_____		

Date of last medical examination_____/_____/_____

Family History:

Mother: ☐Alive ☐Dead Age _____ Health Conditions: _____

Father: ☐Alive ☐Dead Age _____ Health Conditions: _____

Number of Siblings: _____

☐ M ☐ F Alive ☐ Dead ☐ Age ____ Health Conditions: _____

☐ M ☐ F Alive ☐ Dead ☐ Age ____ Health Conditions: _____

☐ M ☐ F Alive ☐ Dead ☐ Age ____ Health Conditions: _____

Clinical Summary of Care Wavier

I waive my right to receive a summary of care on each of my office visits with Frontier Integrated Health Center. Therefore my provider will have this summary for each day that I am treated, saved and available should I request it in the future.

X_____ _____

Patient Signature Date