

# Welcome



PATIENT INFORMATION		
Date _____		
Patient _____		
Address _____		
City _____	State _____	Zip _____
E-Mail _____		
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Patient SS# _____		
Occupation _____		
Employer _____		
Employer Address _____		
Employer Phone _____		
Spouse's Name _____		
Birthdate _____ SS# _____		
Occupation _____		
Spouse's Employer _____		
Whom may we thank for referring you? _____		

INSURANCE	
Who is responsible for this account? _____	
Relationship to Patient _____	
Insurance Co. _____	
Group # _____	
Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber's Name _____	
Birthdate _____	SS# _____
Relationship to Patient _____	
Insurance Company _____	
Group # _____	
ASSIGNMENT AND RELEASE	
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	
Responsible Party Signature _____	
Relationship _____	Date _____

PHONE NUMBERS	
Home/Cell _____	
Work _____	Ext _____
IN CASE OF EMERGENCY, CONTACT:	
Name _____	Relationship _____
Home Phone _____	
Work Phone _____	Ext _____

ACCIDENT INFORMATION	
Is condition due to an accident? <input type="checkbox"/> Y <input type="checkbox"/> N Date _____	
Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other	
To whom have you made a report of your accident?	
<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Worker's Comp. <input type="checkbox"/> Other	
Attorney Name (if applicable) _____	

PATIENT CONDITION	
Reason for visit _____	
When did your symptoms appear? _____	
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Mark an X on the picture where you continue to have pain, numbness, or tingling.	
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____	
Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Numbness <input type="checkbox"/> Aching <input type="checkbox"/> Shooting	
<input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Cramps <input type="checkbox"/> Stiffness <input type="checkbox"/> Swelling	
How often do you have this pain? _____ Is it consistent, or does it come and go? _____	
Does it interfere with your <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Recreation	
Activities or movements that are painful to perform: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	

