PATIENT'S NAME:

FIRST:_____

MIDDLE:_____

LAST:_____

PATIENT'S BIRTH DATE: _____/_____/_____

PATIENT'S GENDER: M ☐ F ☐

PATIENT'S SSN:_____

STREET:_____

CITY:_____

STATE:_____ **ZIP CODE:** _____

PLEASE CHECK BOX FOR PREFERRED PHONE NUMBER TO CALL.

☐ **HOME PHONE**:_____

☐ **CELL PHONE**:_____

SERVICE PROVIDER:_____

☐ Check if you would like text messages.

EMAIL ADDRESS:_____

REFERRED BY:_____

☐ **PERSONAL INJURY OR** ☐ **WORKMAN'S COMPREHENSION**

DATE OF ACCIDENT:_____

TIME OF ACCIDENT:_____

MEDICAL PAY INSURANCE NAME:_____

MEDICAL PAY CLAIM NUMBER:_____

MEDICAL PAY ADJUSTER:_____

MEDICAL PAY ADDRESS:_____

STATE, CITY ZIP:_____

MEDICAL PAY PHONE:_____

THIRD PARTY INSURANCE NAME:_____

THIRD PARTY CLAIM NUMBER:_____

THIRD PARTY ADJUSTER:_____

THIRD PARTY ADDRESS:_____

STATE, CITY ZIP:_____

THIRD PARTY PHONE:_____

ATTORNEY NAME:_____

ATTORNEY'S ADDRESS:_____

STATE, CITY ZIP:_____

ATTORNEY'S PHONE:_____

BUSINESS NAME:_____

NAME OF SUPERVISOR:_____

EMPLOYER'S STREET ADDRESS:_____

STATE, CITY ZIP:_____

SUPERVISOR'S PHONE:_____

WORKMAN'S COMP CLAIM NUMBER:_____

IS THERE A REFERRAL REQUIRED? ☐ YES ☐ NO

DO YOU HAVE A REFERRAL FORM? ☐ YES ☐ NO

DID YOU GO TO ANOTHER DOCTOR? ☐ YES ☐ NO

EMERGENCY CONTACT:_____ **PHONE:**(_____)_____-_____

PATIENT STATUS: SINGLE ☐ MARRIED ☐ OTHER ☐ _____

EMPLIYMENT/STUDENT STATUS: EMPLOYED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT ☐

EMPLOYER'S NAME OR SCHOOL NAME:_____

IS PATIENT'S CONDITION RELATED TO: EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

AUTO ACCIDENT? ☐ YES ☐ NO PLACE (STATE):_____

OTHER ACCIDENT? ☐ YES ☐ NO

ETHNICITY/RACE: ☐ Caucasian ☐Hispanic or Latino ☐Black/African American ☐American Indian/Alaskan Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Two or more ☐Other:_____

PLEASE LIST HEALTH HISTORY, THE CONDITION AND THE RELATIVE (i.e., Mother, Father, Sister, Brother, Son, Daughter, Etc.)

Health Condition	Relative

PREFERRED LANGUAGE: ☐English ☐Spanish ☐Other:_____

If there is an emergency, in which language would you like to receive the message?_____

SMOKING STATUS: ☐ Smokes every day ☐ Smokes some days ☐ Former Smoker ☐ Never Smoked

If you smoke, how many cigarettes do you smoke per day?_____

Have you been diagnosed with either of the following? ☐ Asthma ☐ Diabetes ☐ High Blood Pressure

I would like to electronically have access to my health information: ☐ Yes ☐ No

For confidential correspondence, please create a Secret Question, i.e., What was my first pet's name?

Secret Question:_____ **Secret Answer**:_____

PLEASE CHECK HEALTH TOPICS YOU WOULD LIKE TO LEARN MORE ABOUT.

☐ CLINIC ANNOUNCEMENTS, EVENTS AND 0FFERINGS
☐ STRESS MANAGEMENT
☐CHILDREN'S HEALTH ISSUES
☐WOMEN'S HEALTH ISSUES
☐EXERCISE & FITNESS
☐DIET & NUTRITION
☐WELLNESS TOPICS
☐HEADACHES & NECK PAIN
☐BACKACHES & SCIATICA

IF YOU HAVE HAD THIS SAME OR SIMILAR ILLNESS, GIVE FIRST DATE: _____/_____/_____

PRESCRIBED MEDICINES: ☐ CHECK HERE IF YOU ARE NOT TAKING ANY MEDICATIONS.

MEDICATION i.e., Lipitor	**# OF MD REFILLS ISSUED**	**QUANTITY**	**STRENGTH** i.e., 10 mg	**DOSE FORM** i.e., Capsule	**MD'S INSTRUCTIONS** i.e., 1 per day

ARE YOU ALLERGIC TO ANY MEDICINES? PLEASE LIST EACH DRUG ON A NEW LINE:

☐ CHECK HERE IF YOU DO NOT HAVE ANY MEDICAL ALLERGIES.

NAME OF DRUG i.e., penicillin	**SYMPTOM** i.e., headache	**SEVERITY** **Mild / Mild to Moderate / Moderate / Moderate to Severe / Severe / Fatal**

Patient Signature:_____ **Date**_____

Parent/Guardian Signature if Patient is a Minor:_____ **Date:**_____

OFFICE USE ONLY:

TA ☐ **MED/ALLERGIES** ☐ Entered by:_____ Date:_____/_____/20_____ Time: _____:_____

Blood pressure:_____/_____ **Pulse**: _____ **Height**:_____'_____" **Weight**:_____