Patient Information Form
(Please Print)

Date: _____ / _____ / _____

Patient Information

Patient Name: _____ _____ Date of Birth: ____ / ____ / ____ Sex: □ M □ F
Last First

Home Address: _____ City: _____ State: _____ Zip: _____

SSN #: _____ - ____ - _____ Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____

Work #: (_____) _____ - _____ Ext #: _____ E-Mail: _____

Primary Language: _____ Race/Ethnicity: _____
□ Prefer not to report

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Employer: _____ Occupation: _____

Do you have a legal guardian or healthcare power of attorney? □ Yes □ No

If Yes, Name: _____ Relationship: _____ Phone #: (_____) _____ - _____

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____ - _____

Primary Care Doctor: _____ Who referred you to us? _____

Pharmacy: _____ Location: _____ Phone #: (_____) _____ - _____

Is there a family member or other person you would like for us to share your medical information?

□ Yes Name(s)_____
□ No

Insurance Information

Company: _____

Insured's Name: _____ Insured's Date Of Birth: ____ / ____ / _____

Insured's SSN #: _____ - _____ - _____

Current Problem

What specific problem brings you to our office today? _____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

How would you describe your pain? □ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Itching □ Stabbing □ Other: _____

How would you rate your pain on a scale from 0 to 10? (Please circle)

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

What treatments have you had for this problem? _____

Was this problem cause by an injury? □ Yes (describe) _____
□ No

If Yes, was this a work related injury? □ Yes
□ No

Where is the pain / problem located? Please mark on the pictures below:

Medical History

Allergies: □ None Known □ Medications: _____
□ Anesthesia □ Tape □ Latex □ Shellfish □ Iodine □ Food □ Other_____

Have you ever had any of the following?

Acid Reflux	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Anemia	Y	N	Gout	Y	N	Open Sores	Y	N
Arthritis	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Asthma	Y	N	Heart Disease/Failure	Y	N	Polio	Y	N
Back Trouble	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Bladder Infections	Y	N	HIV+/AIDS	Y	N	Sickle Cell Disorder	Y	N
Abnormal Bleeding	Y	N	High Blood Pressure	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	Kidney Disease	Y	N	Sleep Apnea	Y	N
Blood Transfusion	Y	N	Liver Disease	Y	N	Stomach Ulcers	Y	N
Bronchitis/Emphysema	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Migraine Headaches	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N

Height:_____ Weight:_____ Shoe Size:_____

Please List all prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all prior hospitalizations (Other than for Surgery)

Reason for hospitalization	Date	Reason for hospitalization	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all medications you are currently taking:

Name	Dose	How often do you take them?
_____		
_____		
_____		
_____		
_____		

Family History

Do you have a family history of: □ Diabetes □Cancer □ Heart Disease □ High Blood Pressure
□ Stroke □ Coronary Artery Disease □ Thyroid Disease □ Arthritis □ Other: _____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____

Print name of patient, Parent/Guardian

_____

If other than patient, relationship to patient

_____

Signature

_____

Date

Authorizations

Benefits to Physician:

☐ Yes ☐ No I hereby authorize payment directly to the physician of the surgical and/or medical benefits.

☐ Yes ☐ No I also understand I am responsible for any portion of my bill not covered by my insurance company.

Release of Information:

☐ Yes ☐ No The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

Date: ____/____/_____ Signature: _____ Guardian: _____

Acknowledgement of receipt of notice of Privacy Practices:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understand the notice.

Date: ____/____/_____ Signature: _____ Guardian: _____