Date: _____

For office use only	
Patient #	**Type:**

Name: _____ Date of Birth: _____ Age: _____
First Middle Last

Address: _____ SSN#: _____
City State Zip code

Email Address: _____ Referred to our office by: _____

Telephone: Home: _____ Work: _____ Cell: _____

Occupation: _____ Employer: _____

Date of Injury or Accident If any: _____ Insurance: _____ Attorney: _____

Marital Status: **S M D Sep. W** Spouse: _____DOB:_____SS#_____

In Case of Emergency, please give the name of a relative or close friend NOT living with you.

Name: _____Relationship to Patient: _____

Address: _____Home#: _____ Cell #:_____

Recent X-rays, MRI, CT? YES NO Place Taken: _____

Allergies: N Y Explain:_____ Smoke: N Y How much: _____

Please list all MEDICATIONS/ surgeries and/or hospitalizations: _____

_____

Family History: Disease, Relative (Mother, Father, Aunt, Uncle etc.)

Disease	Relative	Disease	Relative	Disease	Relative
☐ Heart Disease	_____	☐ Stroke	_____	☐ Asthma	_____
☐ Sudden Death	_____	☐ High Blood Press.	_____	☐ Seizures	_____
☐ Cancer	_____	☐ Diabetes	_____	☐ other _____	_____

PLEASE CHECK THE BOX IF YOU HAVE OR HAVE HAD ANY OF THESE SYMPTOMS.

☐ Headaches	☐ Knee Pain	☐ Sinus/Allergies	☐ Cold hands	☐ Alcohol/Drug Abuse
☐ Neck Pain	☐ Tension	☐ Loss of smell	☐ Cold feet	☐ Seizures
☐ Stiff Neck	☐ Dizziness	☐ Loss of taste	☐ Fever	☐ Shingles
☐ Numbness in fingers	☐ Sleeping Problems	☐ Kidney problems	☐ Diarrhea	☐ Diabetes
☐ Numbness in toes	☐ Depression	☐ Urinary Problems	☐ Stomach upset	☐ Psychiatric problems
☐ Pins & needles in arms	☐ Chest pain	☐ Buzzing in ears	☐ Irritability	☐ Hemorrhoids
☐ Pins & needles in legs	☐ Heart attack/stroke	☐ Ringing in ears	☐ Ulcers	☐ Cancer/Chemo
☐ Shoulder/arm pain	☐ High blood pressure	☐ Eyes bothered by light	☐ Constipation	☐ Hepatitis
☐ Upper back pain	☐ Cold sweats	☐ Menstrual pain/irregularity	☐ Asthma	☐ Aids
☐ Mid back pain	☐ Mood swings	☐ Pregnant	☐ Anemia	☐ Other
☐ Lower back pain	☐ Fainting	☐ Date of last menstrual cycle	☐ Arthritis	_____
☐ Leg/hip pain		_____		

PLEASE READ: I understand and agree by signing below that my health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that this Clinic will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Clinic 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 responsible for the payment of these services in full. I also understand that if I suspend or terminate my care in office, any and all outstanding charges for professional services rendered to me will become immediately due and payable by myself personally at the full retail price. I also agree to pay any delinquency or legal fees that may occur if I do not pay my bill in a timely fashion and it is placed in collections or court.

SIGNATURE: _____ DATE: _____

(Signature of Parent/Guardian required if patient under age 18)