WELCOME

PATIENT INFORMATION

Date_____

Patient_____

Home Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ 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?_____

e-mail address:_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

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_____ Work_____ Ext____

Cell Phone_____

IN CASE OF EMERGENCY, CONTACT:

Name_____ Relationship_____

Home Phone_____

Work Phone_____ Ext____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)_____

STUDENT INFORMATION

School Address_____

_____

City State Zip

Bill me at this address ____ -or- Bill my parents at my home address above____

Parents Name_____

If your address, telephone number or email address should change, be sure to supply us with this Information.

Thank You

Office Use Only:
- ☐ Rapid
- ☐ Rcopia

Additional Patient Information

Vitals:

Height _____ft _____in

Weight_____lbs

Blood Pressure: Rt ___ Lt___

_____/_____ Pulse:_____

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? _____

Are you current taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes. What? _____ Dose:_____ Form:_____ How Often:_____
  - What? _____ Dose:_____ Form:_____ How Often:_____
  - What? _____ Dose:_____ Form:_____ How Often:_____
  - What? _____ Dose:_____ Form:_____ How Often:_____
  - What? _____ Dose:_____ Form:_____ How Often:_____

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker