

Please fill in the name of the patient who is being seen today

Male Female

First Name Middle Initial Last Name

Address City State Zip

Home Telephone Cell or other Telephone Date of Birth Social Security #

Please fill in the name of the person responsible for paying the medical charges

Mr. / Mrs. / Ms. First Name Middle Initial Last Name Suffix (jr, MD, etc)

Address City State Zip

Home Telephone Work Telephone Cell or other Telephone

Single Married Domestic Partner Other

Date of Birth Social Security Number Marital Status

Retired Employed Unemployed

Employment Status Occupation & Employer's Address (if retired, occupation prior to retirement)

Primary Insurance Information

Secondary Insurance Information

Name of Insurance Provider

Name of Insurance Provider

Claims Address City State Zip

Claims Address City State Zip

Member's ID Number Group Number

Member's ID Number Group Number

Specialty CoPay

Specialty CoPay

Who is the doctor or ER who referred you to our clinic?

Who is your primary care doctor?

Name

Name

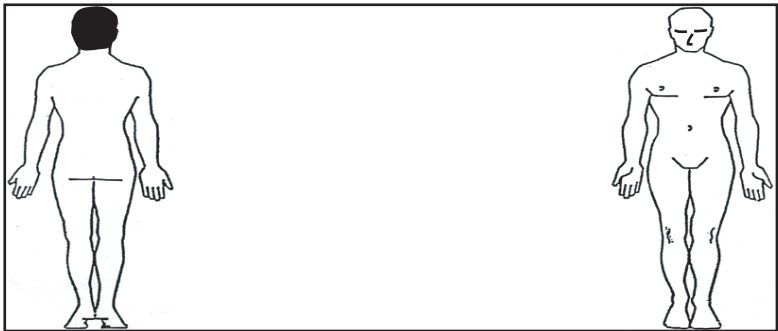
Address City State Zip

Address City State Zip

Telephone Fax

Telephone Fax

Where are you hurt? (please draw on the body diagrams to indicate where you feel pain, numbness, or other discomfort)



How did this injury happen? What day did it happen on? Where did it happen?

Please list any other medical problems that the patient has, any prior surgeries, and any medications that are taken.

Which Pharmacy do you use (Name & Location)

Please list any allergies that you have

allergy	reaction	allergy	reaction

Personal and Family Review of Systems: circle = patient box = family member

- | | | |
|--|---|--|
| <input type="radio"/> <input type="checkbox"/> arthritis | <input type="radio"/> <input type="checkbox"/> stomach ulcers | <input type="radio"/> <input type="checkbox"/> psychologic problems |
| <input type="radio"/> <input type="checkbox"/> hypertension | <input type="radio"/> <input type="checkbox"/> fainting | <input type="radio"/> <input type="checkbox"/> depression |
| <input type="radio"/> <input type="checkbox"/> cancer | <input type="radio"/> <input type="checkbox"/> rashes | <input type="radio"/> <input type="checkbox"/> poor vision |
| <input type="radio"/> <input type="checkbox"/> mental health problems | <input type="radio"/> <input type="checkbox"/> seizures | <input type="radio"/> <input type="checkbox"/> poor hearing |
| <input type="radio"/> <input type="checkbox"/> blood clots, bleeding disorders | <input type="radio"/> <input type="checkbox"/> obesity | <input type="radio"/> <input type="checkbox"/> rheumatologic illness |
| <input type="radio"/> <input type="checkbox"/> diabetes | <input type="radio"/> <input type="checkbox"/> weight loss | <input type="radio"/> <input type="checkbox"/> ADHD |
| <input type="radio"/> <input type="checkbox"/> bad reaction to anesthesia | <input type="radio"/> <input type="checkbox"/> liver disease | <input type="radio"/> <input type="checkbox"/> IV drug use |
| <input type="radio"/> <input type="checkbox"/> cardiac disorders | <input type="radio"/> <input type="checkbox"/> kidney stones | <input type="radio"/> <input type="checkbox"/> alcoholism |
| <input type="radio"/> <input type="checkbox"/> hepatitis | <input type="radio"/> <input type="checkbox"/> urinary difficulty | <input type="radio"/> <input type="checkbox"/> prior blood transfusion |
| <input type="radio"/> <input type="checkbox"/> HIV/AIDS | <input type="radio"/> <input type="checkbox"/> scoliosis | <input type="radio"/> <input type="checkbox"/> recent travel |

RELEASE OF MEDICAL INFORMATION AND FINANCIAL RESPONSIBILITY

We are contracted with some insurance carriers and may be able to bill directly for you. Please provide us with a copy of your insurance card, If a copayment or deductible is part of your plan, we require that your portion be paid at the time of service. We will make every effort to provide you with an accurate amount due at the end of your visit today.

I hereby authorize the release of any needed medical information to insurance carriers to process a claim, and request that payment be sent to the doctor's office for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance, and that I will be expected to pay if insurance has not paid within 60 days. This medical practice may add monthly rebilling fees for overdue balances.

Signed _____ Date _____

Designation of Personal Representatives & Notice of Privacy Practices

I, _____ have have been given the opportunity to read and review this office's Notice of Privacy Practices.

Signed _____ Date _____

I authorize the following person/persons to be my personal representative, which means the doctor and staff may speak freely to the named personal representative regarding all of my protected health information

_____ Name	_____ Relationship to Patient	_____ Name	_____ Relationship to Patient
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Consent for Treatment if Patient is a Minor

I grant the physicians associated with the practice the authority to administer treatments and perform such procedures as may be deemed necessary for the above patient.

Signed _____ Relationship to Patient _____ Date _____