

PERSONAL AND HEALTH INFORMATION

Name _____ Date of Birth _____ Occupation _____

Address _____ City _____ State _____ Zip Code _____ Phone _____

Business Phone _____ Social Security Number _____ Number of Children _____

Marital Status: M S D W Spouse's Name _____ Spouse's Work Phone _____

In case of emergency, nearest relative's name: _____ Phone Number: _____

**For our monthly Newsletter please note your E-mail address: _____

How did you hear about us?

Please circle *Referral *Mail *Newspaper *Phonebook *Location *Website *Walk-in *Insurance

*Special Event (which one) _____ *Other _____

Who may we thank for referring you to our office? _____

HEALTH HISTORY

What is/are the health condition(s) you are concerned with today?

*Major complaint? _____

*Onset? _____

Which of the following illnesses have you had? (Please circle)

Arthritis	Asthma	Sinus Trouble	Allergies/Hay fever
Tuberculosis	Diabetes	Epilepsy	High/Low Blood Pressure
Thyroid Trouble	Heart Trouble	Spinal Disc Disease	Multiple Sclerosis
AIDS/HIV	STD	Ulcer	Mental/Emotional Difficulty
Cancer	Polio	Kidney Trouble	Serious Injury
Bone Fracture	Rheumatic Fever	Scoliosis	Dislocated Joints

Women: Are you currently pregnant? _ Yes _ No First Day of Last Menstrual Cycle: _____

INSURANCE INFORMATION

Do you intend to use health insurance? _ Yes _ No (please see note below)

Are you covered by Medicare? _ Yes _ No

Are you covered by Medicaid? _ Yes _ No

PAYMENT INFORMATION

PLEASE NOTE: On your first visit, payment is due in full at the time of service, unless prior arrangements were made. We **DO** accept insurance assignment, but **NOT** until we are able to contact your insurance carrier directly to verify benefits. Payment you make today which is verified to be covered by insurance will be credited to your account, or reimbursed upon your request.

Based on this, payment today will be: _____ Cash _____ Check _____ Credit Card (Visa, MC, or AmExp)

I authorize the doctor to evaluate and care for me as he/she deems appropriate. I understand and agree that all services rendered me at this office are my financial responsibility and are charged directly to me. Even if submitted to insurance, ultimately, I am personally responsible for payment.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____