

E MAIL _____

CONFIDENTIAL PATIENT INFORMATION _____ DATE _____

NAME _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ DATE OF BIRTH _____ SEX M/F MARITAL S M D W #CHILDREN _____

OCCUPATION _____ EMPLOYER _____ PHONE _____ EXT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____

NEAREST RELATIVE _____ TELEPHONE NUMBER _____

HAVE YOU HAD ANY PRIOR INJURIES? _____

WHAT OPERATIONS HAVE YOU HAD? _____

ANY SERIOUS ILLNESS? _____ ARE YOU PREGNANT? YES/NO

OTHER DOCTORS SEEN FOR THIS CONDITION _____

WHAT MEDICATIONS OR DRUGS YOU ARE TAKING? _____

IF YOURS IS AN ACCIDENTAL INJURY PLEASE COMPLETE THE INFORMATION REQUESTED ON THE REVERSE SIDE

HABITS		EXERCISE		FAMILY HISTORY				
<input type="checkbox"/> Smoking	Packs/Day: _____	<input type="checkbox"/> None		Diabetes	Heart	Kidney	Cancer	Back
<input type="checkbox"/> Drinking	Alcohol: _____	<input type="checkbox"/> Moderate	Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coffee	Cups/Day: _____	<input type="checkbox"/> Daily	Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Type: _____	Brother, # of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Sister, # of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

WHICH HAND DO YOU USE? () RIGHT OR () LEFT

CHANGE IN URINARY FUNCTION? () YES OR () NO

PAYMENT IS EXPECTED AT TIME OF VISIT!

ARE YOU INSURED? YES/NO COMPANY _____ POLICY _____

CLAIM # _____ ADJUSTER _____ TELEPHONE _____

PATIENT'S SIGNATURE _____ SOCIAL SECURITY _____

GUARDIAN OR SPOUSE'S SIGNATURE AUTHORIZING CARE _____

INFORMATION TAKEN BY _____ DATE _____

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?



- | | | |
|---------------------|-----------------|----------------------|
| () APPENDICITIS | () ANEMIA | () HEART DISEASE |
| () PNEUMONIA | () MEASLES | () GOITER |
| () RHEUNATIC FEVER | () MUMPS | () INFLUENZA |
| () POLIO | () CHICKEN POX | () PLEURISY |
| () TUBERCULOSIS | () DIABETES | () ALCOHOLISM |
| () WHOOPING COUGH | () CANCER | () VENEREAL DISEASE |
| () ARTHRITIS | | () LUMBAGO |
| | | () ECZEMA |