PLEASE PRINT

OFFICE USE ONLY: DATE: ____________ ACCT # ____________

CAT. ____________ DR. ____________

PATIENT'S NAME ______________________________ SEX ______ SS # ____________ DOB ________ AGE ______
(LAST) (FIRST) (MIDDLE)

ADDRESS ______________________________ DRIVER'S LICENSE # ____________
(STREET) (APT#) (CITY) (STATE) (ZIP)

HOME PHONE ____________ CELL PHONE ____________ EMAIL ____________

☐ SINGLE ☐ MARRIED SPOUSE'S NAME ____________ SPOUSE'S DAYTIME PHONE ____________

WHERE IS YOUR PAIN? ____________ DATE OF ONSET ____________ REFERRED BY ____________

PAIN SCALE: 1 2 3 4 5 6 7 8 9 10

PATIENT'S EMPLOYER ____________ OCCUPATION ____________ WORK PHONE ____________

PRIMARY CARE PHYSICIAN ____________ EMERGENCY CONTACT ____________ PHONE ____________

IF THE PATIENT IS A MINOR, COMPLETE THE FOLLOWING:

FATHER'S NAME ______________________________ SS# ____________

ADDRESS IF DIFFERENT FROM PATIENT ______________________________ WORK PHONE ____________

MOTHER'S NAME ______________________________ SS# ____________

ADDRESS IF DIFFERENT FROM PATIENT ______________________________ WORK PHONE ____________

MEDICAL INFORMATION

ALLERGIES TO MEDICATIONS ______________________________

LIST OTHER MEDICAL PROBLEMS ____________ MEDICATIONS TAKEN ____________

HAVE YOU SEEN ANOTHER DOCTOR FOR THE CHIEF COMPLAINT? ☐ YES ☐ NO NAME ____________

INSURANCE INFORMATION

PRIMARY INSURANCE PLAN NAME ____________ POLICY # ____________ GROUP # ____________

POLICY HOLDER NAME ____________ RELATIONSHIP TO PATIENT ____________

INSURED'S DATE OF BIRTH ____________ SEX OF INSURED ☐ MALE ☐ FEMALE

SECONDARY INSURANCE PLAN NAME ____________ POLICY # ____________ GROUP # ____________

OTHER INSURED'S DATE OF BIRTH ____________ SEX OF OTHER INSURED ☐ MALE ☐ FEMALE

COMPLETE THIS SECTION IF WORKMEN'S COMPENSATION OR AUTOMOBILE ACCIDENT:

☐ WORKMEN'S COMPENSATION ☐ AUTOMOBILE ACCIDENT CLAIM # ____________

DATE OF INJURY/ACCIDENT ____________ INSURANCE CARRIER ____________

CARRIER ADDRESS ______________________________ PHONE ____________

EMPLOYER AT THE TIME OF INJURY ______________________________ PHONE ____________

COMPLETE ONLY IF AN ATTORNEY IS REPRESENTING YOU FOR YOUR INJURY:

ATTORNEY'S NAME ______________________________ PHONE ____________

ATTORNEY'S ADDRESS ______________________________
(ASK RECEPTIONIST FOR AN AUTHORIZATION FORM)

I AM AUTHORIZING AN EXAMINATION AND/OR TREATMENT BY THE PHYSICIAN. I ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES (IMEs EXCLUDED) INCURRED REGARDLESS OF INSURANCE, COMPENSATION OR POSSIBLE LITIGATION AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MY PHYSICIAN. I ALSO UNDERSTAND THAT ALL BILLS ARE DUE UPON RECEIPT. PATIENT (OR LEGAL GUARDIAN) AGREES TO PAY LEGAL FEES INCURRED IN THE COLLECTION OF PAST DUE ACCOUNTS.

SIGNATURE ______________________________ DATE ____________