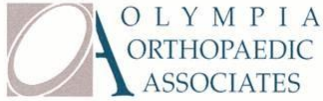




Complete Entire Section/Please Print Clearly			
Date:	Male ____ Female ____	Date of Birth:	Patient Social Security Number
Patient Name (Last, First, Middle):		Home Phone:	Cell Phone:
Address: State/Apt #: _____ City: _____ State: _____ Zip: _____			
Employment Information:			
Patient Employer Name:		Occupation:	Work Number:
Complete if the responsible party is different from patient			Emergency Contact (outside of Home)
Spouse/Parent/Legal Guardian:			Emergency Contact Name:
Social Security Number:	Phone:	Relationship to Patient:	
Address:	Work Phone Number:	Contact Phone Number:	
Authorized/Unauthorized Person(s) to Release Personal Account Information			
Name:	Circle One: Release/Deny	Security Question (fill in one or all) Favorite Color	
Name:	Release/Deny	Mothers Maiden Name:	
Name:	Release/Deny	City of Birth:	
Primary Care and Referring Doctor Information			
Primary Care Physician (Name, Address, Phone #):		Referring Doctor (Name, Address, Phone #)	
Reason for Visit, Body Region:		Side Affected: Lt. _____ Rt. _____ Bilateral _____	
		Onset Date: ____/____/____	
***Insurance Information: ____ Please check if you have no insurance			
Primary Insurance Company:	Subscriber Name:	Insurance ID #:	Group #:
Secondary Insurance Company:	Subscriber Name:	Insurance ID #:	Group #:
State/Self Insured Workman's Comp (Name, Address, Phone #)	Claim #	Date of Injury:	
<b>Authorization for Release of Medical Records:</b> We must have your authorization to release medical information to your insurance carrier or physician for payment upon request. My signature verifies that authorization.			
<b>Medicare-Lifetime Authorization:</b> I authorize Medicare benefits be made to me or on my behalf to my physician for any services furnished to me by that physician. I authorize any holder of my medical information to release any information to the health care financing administration and its agents that may be needed to determine these benefits or the benefits payable for related services. I hereby authorize medicare to furnish the above named doctor any information regarding my Medicare claims in title XVII of the Social Security Act.			
<b>Referral:</b> I understand that it is my obligation to obtain a referral for any services if one is required by my insurance. This referral may also require approval by my primary care doctor. If I fail to provide an appropriate referral, I accept full responsibility for any charges incurred in the course of treatment.			
<b>Guarantee of Eligibility:</b> I understand I am financially responsible for any balance not covered by my insurance carrier. I also understand that should I provide incorrect or untimely information regarding my primary care provider, my insurance coverage, or if I am not eligible under the terms of my medical subscriber agreement, I am liable for all charges for services rendered. A copy of this signature is valid as the original.			

Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_



MEDICAL HISTORY FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age \_\_\_\_\_ Sex: M or F (circle) Height \_\_\_\_\_ Weight \_\_\_\_\_ Are You: left or right handed (circle)

Occupation: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

**Past Medical History:** Do you have or have you ever had: Please circle

High Blood Pressure	Y N	Hepatitis	Y N	Sleep Apnea	Y N	Cancer	Y N
Diabetes	Y N	Do you take Insulin	Y N	Heart Disease	Y N	Angina	Y N
Arthritis	Y N	Stroke	Y N	MRSA	Y N	Asthma	Y N
Thyroid Condition	Y N	Stomach Ulcers	Y N	GI Disease	Y N	Gout	Y N

**Other Medical Conditions not listed above:**

\_\_\_\_\_

**Prior Surgeries:** (Type of surgery; date of surgery)

\_\_\_\_\_

**Present Medications:** (Name of medication; Strength/dosage; How often taken)

\_\_\_\_\_

**Are You Taking Blood Thinners?** Y N Please circle: Coumadin Plavix Warfarin Aspirin

**Medication Allergies:** (Indicate medication and type of reaction)

\_\_\_\_\_

**Have you had ANY reactions to pain medications?** (Nausea, vomiting, etc...) If yes which medications?

\_\_\_\_\_

**Do you have an allergy to Latex?** Y N **Do you have an allergy to Metal?** Y N

**Habits:** Smoking Y N How Much? \_\_\_\_\_ Alcohol Y N How Much? \_\_\_\_\_

**Family History:** Is there a family history of Diabetes, Heart Disease, Cancer, other Diseases?

\_\_\_\_\_

**System Review:** Do you experience any of the following problems? Please circle

Fever	Y N	Chills	Y N	Weight Loss	Y N	Vision Problems	Y N
Wear Glasses	Y N	Hearing Loss	Y N	Sinus Problems	Y N	Chest pain	Y N
Difficulty Breathing	Y N	Short of Breath	Y N	Heartburn	Y N	Diarrhea	Y N
Constipation	Y N	Urinary Difficulty	Y N	Joint Stiffness	Y N	Joint Swelling	Y N
Skin Rashes	Y N	Skin Problems	Y N	Seizures	Y N	Memory Loss	Y N
Depression	Y N	Diabetes	Y N	Anemia	Y N	Blood Disorders	Y N
Hay Fever	Y N	Wheezing	Y N				

Patient Signature \_\_\_\_\_ Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_