PATIENT INFORMATION & CONDITION FORM

Patient Name_____ Today's Date_____

Birth Date_____ Age_____

Marital status: married separated widowed single

Street Address:_____

City/state/zip:_____

Phone:_____

Name of spouse:_____ Spouse date of birth: _____

If you are under 18 years of age: Name of parent or legal guardian:_____

Guardian Phone_____ Guardian Date of Birth_____

Who should we contact in the event of an emergency _____

Relationship:_____ Phone:_____

How did you learn about us._____

Is your condition or injury due to an auto accident or work-related cause? **YES? SEE FRONT DESK**

NO? CONTINUE ONTO NEXT QUESTION

If the condition did NOT result from an automobile accident or relate to your work, where did the accident occur?_____

Approximate, when did your injury or condition occur?_____

Describe your condition symptoms or the purpose of this appointment._____

_____

Have you ever had the same or similar condition? Yes No If yes, when and describe._____

_____

Please indicate any other healthcare providers who you've seen for this injury or condition, and when you last saw them.

Name_____ Date seen_____

What surgeries have you had and when_____

_____

Serious illnesses or conditions and when_____

Have you been treated for any health condition by a physician in the past year? Yes No

Describe_____

What medication or drugs are you currently taking?_____

_____

Have you suffered from: (circle)

dizziness	arthritis	digestive disorders
backaches	headaches	nervousness
heart trouble	numbness	sinus trouble
diabetes	asthma	anemia
hernia	neuritis	cancer

Are you pregnant or is there any possibility you may be pregnant? Yes No uncertain

Do you have health insurance. Yes No Name of insurance_____

Full name of policy holder (subscriber) and birth date_____

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself not between my insurance company and this office. I agree to pay my patient responsibility. In the event that my insurance company does not pay on my charges, upon request of this office I will immediately pay the balance owing on my account unless otherwise agreed to in writing. I understand that an interest charge may appear on all accounts over 90 days. I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment and will reimburse this office all costs of such collection efforts, including but not limited to all court costs and attorney fees.

I authorize this office to release any medical information relating to my treatment to any insurance companies which may be responsible for paying benefits on my behalf and to any attorney who may be representing me due to my condition and to complete any usual and customary reports and forms at no charge to assist in collection from my insurance companies, attorneys or other payers.

I have read, understood and agree to the fore going. The information which I have provided is true and complete to the best of my knowledge.

Patient's Signature_____ Date_____

Guardian Signature (if applicable)_____