Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist. PLEASE PRINT

Cell Phone: _____ Today's Date _____

E-Mail: _____

Name _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status: S M W D No. of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express

Your Employer _____ Occupation _____ Years on Job ____

Employer Address _____ City _____ State _____ Zip _____

Office Phone _____ Your SS# _____ Driv Lic# _____

Do you have health insurance where you work? Yes ____ No ____ Plan/Group# _____

Insurance Company _____

Name of Spouse or Parent _____ Birthdate _____

Spouse employed by _____ Occupation _____ Years on Job ____

Employer Address _____ City _____ State _____ Zip _____

Office phone _____ Spouse SS# _____ Driv Lic# _____

Does your spouse have health insurance at work Yes ____ No ____ Plan/Group# _____

Describe the Major Complaints that bring you to our office _____

_____

Is your condition due to an accident? Yes ___ No ___ Date of Accident _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an Auto Accident? Past Year _____ Past 5 years _____ Over 5 years _____ Never _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or non covered. I also understand that if I suspend,or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature _____ date _____

Spouse or Guardian's Signature _____ date _____

Notice to our new patients: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met, arrangements must be made in advance before seeing the doctor.

Insurance Cases: On all insurance the deductible must be met in the beginnig unless prior arrangements are made.

AUTHORIZATION AND RELEASE

patient's name | contract number

( ) ( )

AUTHORIZATION TO RELEASE INFORMATION

I authorize the doctor and his staff named below to release any information deemed appropriate concerning my physical condition and treatment to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof. I agree that a photostatic copy of this agreement shall serve as the original.

signature | witness | date

AUTHORIZATION TO PAY DOCTOR/CLINIC

I hereby authorize and direct payment of any medical and surgical expense benefits allowable to the doctor/clinic named below as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the doctor/clinic. I agree that a photostatic copy of this agreement shall serve as the original.

signature | witness | date

Authorization to Pay
Release Authorization
is granted to
Physician Tax ID

HEALTH QUESTIONNAIRE

Name.

Date:

List all your current health problems:

List any other doctors seen and list treatment received and results obtained:

List all surgeries you have had and list dates:

List any medications you are now taking:

Have you ever been in an automobile accident? When?

Have you ever been in an industrial injury or any other injury for which you received treatment? When?

Please check the conditions you have or have had:

( ) AIDS or HIV+
( ) Anemia
( ) Arthritis
( ) Cancer
( ) Epilepsy
( ) Hypoglycemia
( ) Multiple Sclerosis
( ) Parkinson's Disease
( ) Polio
( ) Rheumatic Fever
( ) Tuberculosis
( ) Venereal Disease

FAMILY HISTORY	age	health problems or cause of death
mother:		
father:		
mother's mother:		
mother's father:		
father's mother:		
father's father:		
brothers:		
sisters:		
children:		