

Patient Name: _____ Birth Date: _____

Reason for this Appointment: _____

Condition(s) Symptoms / Pain You Are Currently Experiencing: _____

Are you Pregnant? Yes No

Answer Yes (Y) or No (N) if you have ever had the following health facts:

- | | | | | |
|---|--|---|---|--|
| Y N | Y N | Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Hearing Problem | <input type="checkbox"/> <input type="checkbox"/> Stomachache | <input type="checkbox"/> <input type="checkbox"/> Concussion | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Fever | <input type="checkbox"/> <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> Head or Neck Pain | <input type="checkbox"/> <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> <input type="checkbox"/> Weight Loss | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> <input type="checkbox"/> Intestinal Pain | <input type="checkbox"/> <input type="checkbox"/> Pain in Extremities | <input type="checkbox"/> <input type="checkbox"/> Depression |
| <input type="checkbox"/> <input type="checkbox"/> Fatigue | <input type="checkbox"/> <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> <input type="checkbox"/> Trouble Urinating | <input type="checkbox"/> <input type="checkbox"/> Pain in Spine, Ribs or Pelvis | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Sugar |
| <input type="checkbox"/> <input type="checkbox"/> Numbness | <input type="checkbox"/> <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> <input type="checkbox"/> Swollen Glands |
| <input type="checkbox"/> <input type="checkbox"/> Vision Problems | <input type="checkbox"/> <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> <input type="checkbox"/> Nipple Soreness | <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> <input type="checkbox"/> Anxiety | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> <input type="checkbox"/> Earache | <input type="checkbox"/> <input type="checkbox"/> Excessive Coughing | <input type="checkbox"/> <input type="checkbox"/> Backache | <input type="checkbox"/> <input type="checkbox"/> Neuritis | <input type="checkbox"/> <input type="checkbox"/> Allergies |
| <input type="checkbox"/> <input type="checkbox"/> Cough Blood | | | | |

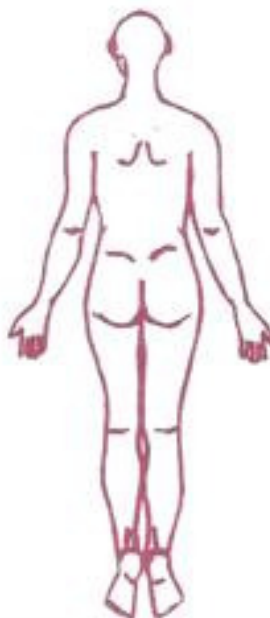
Have you or any bloodline family members ever had the following: (Mark "F" for family and "Y" for you)

- | | | | | |
|--|--|--|--|--|
| F Y | F Y | F Y | F Y | F Y |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> <input type="checkbox"/> Pace Maker |
| <input type="checkbox"/> <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> German Measles | <input type="checkbox"/> <input type="checkbox"/> HIV Positive | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Tumors | <input type="checkbox"/> <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Congenital Disease | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> <input type="checkbox"/> Alcoholism | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Ruptures | <input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> <input type="checkbox"/> Smoker | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Scarlet Fever | | <input type="checkbox"/> <input type="checkbox"/> |

Mark all affected areas on the body with the appropriate symbols that describe your sensations.



- Numbness: = =
 = =
- Pins and needles: ○ ○
 ○ ○
- Aching: X X X
 X X X
- Stabbing: / / /
 / / /



Mark an "X" on the line below that best describes the intensity of your primary complaint.

- Neck: LOW ----- HIGH
- Mid-Back: LOW ----- HIGH
- Low Back: LOW ----- HIGH
- Extremities: LOW ----- HIGH

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ADD ACCOUNT#
 CHG
 DEL

DEAR PATIENT: Please assist us by clearly and correctly completing the information in the **outlined** areas. Do NOT write or mark in shaded areas.
 Please give your insurance card(s) to the receptionist for copying.

PATIENT		FIRST NAME	MIDDLE INIT.	LAST NAME	ACCT. TYPE	
PATIENTS SEX <input type="checkbox"/> 1 MALE <input type="checkbox"/> 2 FEMALE	AGE	BIRTHDAY - -	SOCIAL SECURITY# - -	MARITAL STATUS <input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> DIV <input type="checkbox"/> WID	EMPLOYMENT <input type="checkbox"/> FULL <input type="checkbox"/> PART <input type="checkbox"/> RETI <input type="checkbox"/> UNEMP	STUDENT <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART <input type="checkbox"/> NOT STU
STREET ADDRESS			CITY		STATE ZIP CODE	
HOME TELEPHONE NUMBER () -		EMPLOYER'S TELEPHONE NUMBER () -		EMPLOYER'S NAME	JOB DESCRIPTION	
BILL TO		FIRST NAME (if different than patient)	MIDDLE INIT.	LAST NAME (if different than patient)	MAIL CODE ACCT. TYPE	
STREET ADDRESS (if different than patient)			CITY (if different than patient)		STATE ZIP CODE	
PRIMARY COVERAGE		CARRIER CD NO.	PRIMARY INSURANCE CO. NAME & ADDRESS			
EMPLOYER		PRIMARY INSURANCE CO. CERTIFICATE OR CONTACT #		INSURANCE GROUP NO. OF EMPLOYER		
SOCIAL SECURITY NO. OF POLICY OWNER - -	BIRTHDATE - -	PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER <input type="checkbox"/> DISABLE <input type="checkbox"/>				
POLICY HOLDER NAME						
SECONDARY COVERAGE		CARRIER CD NO.	PRIMARY INSURANCE CO. NAME & ADDRESS			
EMPLOYER		PRIMARY INSURANCE CO. CERTIFICATE OR CONTACT #		INSURANCE GROUP NO. OF EMPLOYER		
SOCIAL SECURITY NO. OF POLICY OWNER - -	BIRTHDATE - -	PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER <input type="checkbox"/> DISABLE <input type="checkbox"/>				
POLICY HOLDER NAME						

AUTHORIZATION THE ABOVE SUBSCRIBER HEREBY AUTHORIZES HIS/HER INSURANCE COMPANY TO ISSUE INDEMNITY CHECKS TO THE ABOVE LISTED MEDICAL PROVIDER FOR SERVICES PROVIDED.

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. * For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. * The patient or his / her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. * I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

DATE _____ **SIGNATURE** X _____
 PATIENT (PARENT/GUARDIAN IF MINOR)

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date _____

Patient Name _____

Date of Accident _____ Time of Accident _____ a.m.

p.m.

Please describe the accident in your own words: _____

Were you the: Driver Front Passenger Rear Passenger Pedestrian

How many people were in the accident vehicle? _____

ACCIDENT SITE

Road/Street Name _____

City/State _____

Nearest intersection with road/street _____

Driving conditions Dry Wet Icy Other _____

Which direction were you headed? _____

Speed you were traveling? _____

IMPACT

Did your car impact another vehicle? Yes No

Did your car impact a structure? Yes No

If yes, explain _____

Did any part of your body strike anything in the vehicle?

Yes No If yes, explain _____

Was impact from:

Front Rear Left Right Other _____

At the time of impact were you:

Looking straight ahead Looking to the right

Looking to the left Looking down

Looking up

Were both hands on the steering wheel? Yes No

If no, which hand was on the wheel? Right Left

Was your foot on the brake? Yes No

If yes, which foot was on the brake? Right Left

Were you: Surprised by impact Braced for impact

VEHICLE

Make and model of vehicle you were in: _____

Were you wearing a seatbelt? Yes No

If yes, what type? Lap Shoulder

Was vehicle equipped with airbags? Yes No

If yes, did it/they inflate properly? Yes No

Did your seat have a headrest? Yes No

If yes, what was the position of the headrest?

Low Midposition High

OTHER VEHICLE

(if applicable)

Make and model of other vehicle _____

Which direction was other vehicle headed? _____

Speed other vehicle was traveling _____

POLICE

Did the police come to the accident site? Yes No

Were there any witnesses? Yes No

Was a police report filed? Yes No

Was a traffic violation issued? Yes No

If yes, to whom? _____