PATIENT INFORMATION

Date _____ Name _____

Preferred Name_____ DOB _____Age _____

Street Address _____ Apt# _____

City _____ State _____ Zip _____

Employer _____ Marital Status S M W D O (Circle One)

Occupation _____ Wk Ph# _____

Email Address _____

Hm# _____Cell# _____

Who referred you to this office _____

Emergency contact_____

Ph#_____Relationship_____

Language: English___Spanish___Indian___Japanese___Chinese___Korean___French___Other___

Race: White___American Indian___Alaska Native___Asian___ Hispanic/Latino___

Native Hawaiian/Pacific Islander___ Black or African American___Decline to Answer___

HEALTH INSURANCE INFORMATION

We will make a copy of your insurance card/s, however, please complete the following:

Are you the policy holder? Y N If no, is it Spouse ___ Parent ___ Employer ___ Other ___

Name of insurance _____ Insured's DOB _____

Do you have secondary benefits? Y N (Circle One)

Secondary Card Holder's Name _____DOB _____

We invite you to discuss with us any questions or concerns regarding our services. The best health care is based on a friendly, mutual understanding between provider, staff and patient.

Our office policy requires payment in full for all services rendered at the time of visit unless arrangements have been made with the business manager. If account is not paid within 90 days from date of service and no financial agreement has been made, you will be responsible for all legal fees and other expenses incurred to collect your account.

I authorize assignment of benefits from my insurance company to this office for services rendered.

I authorize the doctor and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider or staff to release any information required to process and complete my insurance claim.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes of information I have provided.

Signature _____ Date _____

MEDICAL HISTORY:

Are you taking any of the following medications?

Nerve pills ___ Pain killers (including Aspirin) ___ Muscle Relaxers ___ Stimulants ___ Blood Thinners ___
Tranquilizers ___ Insulin ___ Other _____

DO YOU HAVE ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

Y N Heart Attack/Stroke
Y N Congenital Heart Attack
Y N Alcohol/Drug Abuse
Y N HIV/Aids
Y N Frequent Neck pain
Y N High/Low Blood Pressure
Y N Kidney problems
Y N Asthma
Y N Chemotherapy
Y N Arthritis

Y N Heart Surgery/Pacemaker
Y N Mitral Valve Prolapse
Y N Shingles
Y N Emphysema
Y N Glaucoma
Y N Psychiatric problems
Y N Ulcers/Colitis
Y N Sinus problems
Y N Difficulty Breathing
Y N Artificial Joints/Bones

Y N Heat Murmur
Y N Artificial Valves
Y N Hepatitis
Y N Cancer
Y N Anemia
Y N Rheumatic Fever
Y N Severe/Frequent Headaches
Y N Seizures/Epilepsy
Y N Diabetes
Y N Low Back problems

Please list anything you are allergic to _____

List previous surgeries w/year _____

Family Health History (Circle answer) Cancer, Diabetes, Heart Disease, Other _____

Do you take supplements or vitamins? Y N Exercise regularly? Y N Special Diet? Y N Since _____

Do you smoke? Y N Are you wearing heel lifts, inner soles or arch supports? Y N

What is the age of your mattress? _____ Is it comfortable? Y N

Women only: Are you taking birth control? Y N Are you pregnant? Y N Nursing? Y N

Signature _____ Date _____