

WELCOME TO OUR OFFICE

Confidential Patient Information

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): (____) _____ (Work): (____) _____ (Mobile): (____) _____

Email: _____ Referred By: _____

Age: _____ Birth Date: _____ Sex: M / F Marital Status: S / M / W / D

Occupation: _____ Employer & Address: _____

Spouse's Name: _____ Spouse's Work Phone: (____) _____ Number of Children: _____

Emergency Contact: _____ Contact Phone: (____) _____

Date of Last Physical Exam: _____ With Whom: _____ Where: _____

Reported Findings: _____

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): _____

Fractures, Dislocations, Major Dental Work (List Year in Brackets): _____

Conditions You Have Had:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Sinus Troubles |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis / Joint Pain | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Numbness | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Parasites | <input type="checkbox"/> Urinary Trouble |
| <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Yeast / Candida |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatic Fever | _____ |

Purpose of This Appointment: _____

Other Doctors Seen For This Condition: _____

Have You Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe): _____

Medications / Drugs You Are Taking (state reason in brackets following drug): _____

Remarks / Additional Information: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of Person Responsible for Payment: _____

Address & Phone (if different than yours): _____

PATIENT AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give twenty-four hour advance notice of cancellation.

Signature: _____ Parent / Guardian Signature: _____ Date: _____