

HISTORY OF PRESENT COMPLAINT

Date ___/___/___ Referred by: _____

Part of body involved _____ Right _____ Left _____

Date of onset ___/___/___ Time ___ : ___ a.m.
p.m.

Work related YES NO Are you: right handed _____
(or) left handed _____

Accident YES NO Location of accident _____

What happened ? (How did your injury occur or symptoms begin) ? _____

Present Symptoms _____

Have you seen another doctor for this problem ? YES NO

If yes, doctor's name _____

Have you missed work due to your present condition ? YES NO

Last date worked ___/___/___ Date returned to work ___/___/___

What members of your family have been treated in this office before?
by Doctor? _____

PATIENT INFORMATION

Last Name First MI age Date of birth

Address City State Zip (____) _____
Home Telephone

Male _____ Female _____ Marital
Status: S _____ M _____ D _____ W _____

E-mail Address
(____) _____

Employer Name or School Name if student Work Telephone
If student, FULL TIME _____ PART TIME _____

Address City State Zip Patient SS#

Occupation Drivers License #

PRIMARY INSURANCE INFORMATION

Are you required to see a Primary Care Physician for authorization of treatment ? YES NO

Is your insurance plan an HMO ? YES NO

Insured's Name Date of birth

Insured's SS # _____ - _____ - _____ Group or Policy # _____

Insurance Company Name & Address (____) _____
Telephone

Insured's Employer Name & Telephone Annual deductible _____

Insured's relationship to patient _____ **COPAY** _____

SECONDARY INSURANCE INFORMATION

Insured's Name _____ Date of birth _____

Insured's SS# _____ - _____ - _____ Group or ID# _____

Insurance Company Name & Address _____ (____) _____
Telephone

Insured's Employer Name & Address _____ (____) _____
Telephone
Insured's relationship to patient _____

WORKERS' COMPENSATION INFORMATION (IF APPLICABLE)

Workers' Compensation Insurance Carrier & Address _____ (____) _____
Telephone

WCAB Case # (If any) _____ Claim # _____

Claims Adjuster Name _____

PERSONAL INJURY INFORMATION (IF APPLICABLE)

Auto Insurance Carrier & Address _____ (____) _____
Telephone

Policy # _____ Med-pay coverage YES NO

Name of insurance agent _____

Name of Defendant & Insurance Carrier (if applicable) _____

Claim # _____ Telephone (____) _____

ATTORNEY INFORMATION (IF APPLICABLE)

Do you have an attorney for this injury /illness ? YES NO

Attorney Name & Address _____ (____) _____
Telephone

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

Patient signature & consent for treatment _____ / ____ / ____
Date
Person to contact in the event of an emergency:

Name & Address _____ (____) _____
Telephone

Relationship to patient _____

I understand that this office expects payment when services are rendered, unless other arrangements are made.

Signature of responsible party _____ / ____ / ____
Date