FOR OFFICE USE ONLY	Dr.:
Date: Account #:	Referring Dr.:

TO BE COMPLETED BY THE PATIENT Name of Patient:	____Male ____Female DOB:______________Age: Social #:	__Single __Married __Widowed __Divorced

LOCAL INFORMATION	OUT OF STATE INFORMATION
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: ( )	Home Phone: ( )
Work Phone: ( )	Work Phone: ( )

DESCRIBE YOUR INJURY/CONDITION	Is condition/injury related to: __employment __auto accident __other (describe)
Date of Injury:	The STATE in which your injury occurred:

PATIENT'S OCCUPATION	Person outside your home: Phone: Relationship:
Name of Employer: Address:	For emergencies, contact: Phone: Relationship:

FINANCIAL INFO. Party Responsible for Payment	__Same as above __See information below
Name: __Male DOB: __Female Age:	Relationship to patient: __Self ___Child __Spouse __Other
Address: City: State: Zip:	Employer: Address: Phone:

INSURANCE	Please list all insurances
PRIMARY Insurance Carrier	**SECONDARY Insurance Carrier**
Insurance Co. Name	Insurance Co. Name
Address:	Address:
City: State: Zip:	City: State: Zip:

***Notice to the patient**: Continued on the reverse side of this page.*

Name:	Birthdate:	Age:
Describe your problem in detail:	Date, place (work, home, etc.), and how it occurred:	
Occupation: Is injury work-related?	Have you taken time off work? Last date you worked:	
Have you had any x-rays? Where?	Family physician: Referring physician:	

Who referred you to our office?	Current medications:	Dosages:	Allergies:
__A friend __Physician __Adjustor __Attorney __Ad __Our patient __Phone book __Other			Aspirin Codeine Cortisone Demerol Erythromycin Lidocaine Penicillin Sulfa Tetracycline Other

BELOW THIS LINE IS FOR PHYSICIAN USE ONLY

History:

Physical:

X-Ray:

Diagnosis:

Plan:

Patient Name:

PAST MEDICAL HISTORY:
Previous Illnesses. Check all that apply.

__Angina
__Asthma
__Bleeding
__Blood pressure (high)
__Breathing problems
__Burning with urination
__Cancer
__COPD
__Coronary (heart attack)
__Diabetes
__Other illness (describe):

Continued:

_Emphysema
_Glaucoma
_Jaundice or hepatitis
_Kidney or bladder infection
_Lung blood clot
_Phlebitis
_Pneumonia
_Stroke
_Thyroid disease
_Ulcer
_Weight loss

ANESTHESIA HISTORY:
Check each type of anesthesia you have had:

__General
__Local
__Spinal anesthesia
__Regional

If any adverse reactions, please describe.

PAST SURGICAL HISTORY:
List all operations with the month and year.

FAMILY HISTORY:
Mother's age:
Father's age:

Causes of death:

List any illness that runs in your family:

SOCIAL HISTORY:
Who else lives in your household?

Do you smoke?
If so, how much?

Do you drink?
If so, how much?

REVIEW OF SYSTEMS:
__Awaken from sleep with
  __difficulty breathing
  __coughing
__Respiratory problems
__Shortness of breath
__Chest pain or palpitations
__Irregular heartbeat
__Bowel/bladder problems