



1. GENERAL INFORMATION

Patient's full, legal name:
Patient's address:
City/State/Zip:
Home phone: Work phone:
Cell/pager: Gender: Marital status:
Date of birth: Age: Social security number:
Patient's employer/school: Occupation:
Name of group medical insurance through patient's employer:
If married, spouse's name: Spouse's date of birth:
Spouse's employer: Spouse's social security number:
Name of group medical insurance through spouse's employer:

2. MEDICAL INFORMATION

Nature of problem or complaint:
(Please indicate if left or right side is affected.)
If you are being seen for an injury, please provide the following information:
Date(s) of injury:
Where did injury occur?
How did injury occur?
Emergency contact (not living with you): Relationship:
Address:
City/State/Zip: Phone:
Family physician/PCP:
Address:
City/State/Zip: Phone:
Your pharmacy name: Phone:
Your pharmacy location:
How were you referred to our office?
Have you been seen in our office before? Y N If applicable, previous last name:

3. INSURANCE INFORMATION

Name of primary insurance:
Name of secondary or supplemental insurance:
If worker's compensation, automobile, liability, or homeowner's insurance is involved, please complete the following:
Insurance company: Claim number:
Insurance representative: Date of injury:

4. CERTIFICATION

I certify that the information provided above is correct to the best of my knowledge. I understand that a photocopy of this form may be disclosed to my insurance company.
Signature: Date:
(Patient, Personal Representative, or Parent/Guardian if minor)