

## ABOUT YOU

Today's Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name \_\_\_\_\_  
FIRST MIDDLE LAST

What You prefer to be called \_\_\_\_\_

Birthday \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Male  Female

Single  Married  Divorced  Widowed  Separated

Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_

City/ST/Zip \_\_\_\_\_

Home Phone # \_\_\_\_ / \_\_\_\_ - \_\_\_\_

Referred By \_\_\_\_\_

YOUR EMPLOYER'S: Name \_\_\_\_\_

Work Phone # \_\_\_\_ / \_\_\_\_ - \_\_\_\_ Ext. # \_\_\_\_\_

Your Position There \_\_\_\_\_

Retired?  No  Yes

## ABOUT YOUR SPOUSE

Their Name \_\_\_\_\_  
FIRST MIDDLE LAST

Their Employer \_\_\_\_\_

Work Phone # \_\_\_\_ / \_\_\_\_ - \_\_\_\_ Ext. # \_\_\_\_\_

Social Security # \_\_\_\_\_

Their Birthday \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## IN EVENT OF EMERGENCY

Person to Call \_\_\_\_\_

Relationship \_\_\_\_\_

Work Phone # \_\_\_\_ / \_\_\_\_ - \_\_\_\_ Ext. # \_\_\_\_\_

Home Phone # \_\_\_\_ / \_\_\_\_ - \_\_\_\_

## ACCOUNT INFORMATION

Person Ultimately Responsible for Account:

Their Name \_\_\_\_\_

Relationship \_\_\_\_\_

Billing Address \_\_\_\_\_

STREET CITY/ST ZIP

Home Phone # \_\_\_\_ / \_\_\_\_ - \_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone # \_\_\_\_ / \_\_\_\_ - \_\_\_\_ Ext. # \_\_\_\_\_

## MEDICAL HISTORY

What is your present complaint? \_\_\_\_\_

How long have you had this? \_\_\_\_\_

What other problems do you have? \_\_\_\_\_

List Other Doctors Seen for this Condition: \_\_\_\_\_

List Any Serious Accidents and/or Illnesses with Dates: \_\_\_\_\_

List Previous Surgeries/Treatments with Dates: \_\_\_\_\_

List Any Prescriptions/Over-the-Counter Medications You Are Taking: \_\_\_\_\_

List Any Allergies You May Have: \_\_\_\_\_

### FOR WOMEN ONLY:

# of Children \_\_\_\_\_

Are you taking birth control pills?  No  Yes How long? \_\_\_\_\_

Are you pregnant?  No  Yes If yes, how long? \_\_\_\_\_

## INSURANCE

### PRIMARY INSURANCE COMPANY

Co. Name \_\_\_\_\_

Insured's Name \_\_\_\_\_  
FIRST MIDDLE LAST

Relationship to Patient \_\_\_\_\_

Insured's Birthday \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Social Security # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

### SECONDARY INSURANCE COMPANY

Co. Name \_\_\_\_\_

Insured's Name \_\_\_\_\_  
FIRST MIDDLE LAST

Relationship to Patient \_\_\_\_\_

Insured's Birthday \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Social Security # \_\_\_\_\_

Insured's Employer \_\_\_\_\_