WELCOME TO OUR OFFICE

Confidential Patient Information

Name: ______ Date: ______ Birth Date: ______ Age: ______
Address: ______ City: ______ State: ______ Zip: ______
Home Phone: ( ) ______ Work Phone: ( ) ______ Mobile Phone: ( ) ______
Occupation: ______ Referred By: ______ Number of Children: ______
Email address: ______ Sex: M / F Marital Status: S M W D
Spouse's Name: ______ Spouse's Work Phone: ( ) ______
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:

- ☐ Allergies
- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis/Joint Pain
- ☐ Asthma
- ☐ Backaches
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Disorders
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fatigue
- ☐ Headaches
- ☐ Heart Trouble
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Neck Pain
- ☐ Neuritis
- ☐ Nervousness
- ☐ Numbness
- ☐ Parasites
- ☐ Poor Appetite
- ☐ Poor Circulation
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Trouble
- ☐ Venereal Diseaase
- ☐ Weight Loss
- ☐ Yeast/Candida
- ☐ ______

Chief Complaint: ______
Date of Onset: ______
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): ______

PATENT 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: ______