New Patient Health history Form

Patient data

Today's date: __/__/__

First Name: _____ Last Name: _____ DOB: ___/___/___ SS#: _____
Email*: _____
* Your email will NOT be shared with any 3rd parties or be used for occasional office announcements and promotions.

Physical Address:_____ City: _____ State: _____ Zip code: _____
Telephone (Home): _____ (Cell): _____
Marital Status: ___ Occupation: _____ Employer: _____
Emergency Contact: _____ Phone: _____

Current Complaints

Nature of injury (Please Circle): Automobile Work Other
Please Describe:

If Automobile:
Date of Loss: ___/___/___ Do you have PIP on your account? Y or N Claim #: _____
Your car insurance: _____ Attorney that has advised care (if applicable): _____
Other party's (car insurance): _____ (Name): _____ (Claim #): _____
Were you struck from behind / right side / left side / front / Auto was parked
Did your car hit the other car OR did the other car hit your car?
Are you at fault for the accident? Y or N Unknown
As a result of the accident, were traffic citations issued to you or the driver of your car? Y or N
To the driver of the other car? Y or N

If Work:
Date of Loss: ___/___/___ Claim #: _____ Company Involved: _____

Insurance Information (if applicable)

Health Insurance (if any): _____

Medical History

Have you ever been treated for any conditions in the last year? Yes or No
If yes, please describe:

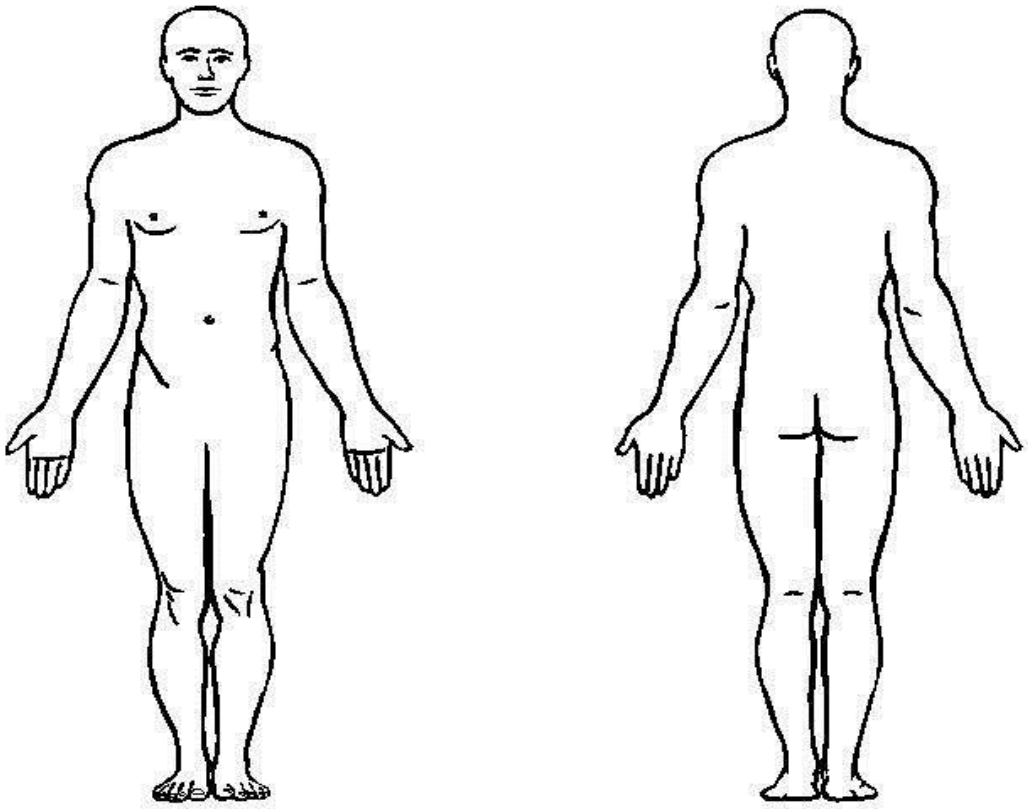
Date of Last Physical Exam: ___/___/___ Is there a chance you may be pregnant? Yes or No
Have you had X-rays taken in the last year? Yes or No
If yes, where? _____
What medications are you taking and for what conditions [Please List for what conditions, dosage, and amounts]

What vitamins, minerals, or herbs do you currently take? [Please list for what conditions, dosage, and frequency]

Have you ever (Please circle):			
Broken Bones?	Y	N	If yes, briefly explain:
Been Hospitalized?	Y	N	If yes, briefly explain:
Been in an auto accident	Y	N	If yes, briefly explain:
Had Surgery?	Y	N	If yes, briefly explain:

Do you… (Circle yes or no?)		
Experience pain every day?	Y	N
Do your symptoms interfere with everyday life?	Y	N
Does pain wake you up at night?	Y	N
What activities aggravate your symptoms?		

Please place an X at the location of the symptoms you are currently experiencing.



I fully understand that am Directly and fully responsible to said doctor for all medical bills submitted by him/her for services rendered and that this agreement is made solely for said doctor's additional protection and in consideration of his/her waiting payment not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest. The doctor will not await payment, but will require me to make payments on a current basis.

I also acknowledge that the receptionist got my insurance information regardless if I want the office to bill my medical Insurance.

Patient's signature: _____ Date: ___/___/___