MAJOR MEDICAL

PATIENT INFORMATION

Date: _____

First Name: _____ Last Name: _____

Address: _____
City/State: _____ Zip Code: _____

Social Security #: _____ DOB: _____ AGE: _____

Sex (circle) MALE / FEMALE
# of Children _____ Marital Status: S M D W Spouses Name: _____

Contact Information:
Home # : _____ Cell # : _____
Work # : _____ Email Adress : _____

In Case of Emergency Contact : _____ Phone # : _____
Are you currently working? _____
Employer : _____ Occupation: _____
Work Address : _____ Phone #: _____

How were you referred to the office? _____
Is your injury work related?_____Was the accident reported? _____
Is your injury related to an Automible Accident? _____

Main Complaint: _____
Secondary Complaint: _____

Have you ever seen another doctor for this complaint? _____
If YES what is the doctors name? _____

PRIMARY DOCTORS NAME:_____Phone: _____

MEDICAL HISTORY

(Please Check if Applicable)

Do you have concerns about your current weight? _____ YES _____ NO

☐ Pregnant	☐ Lymphendema	☐ Headaches	☐ Blood Thinners
☐ Diabetes	☐ Stroke	☐ High Blood Pressure	☐ Other
☐ TMJ	☐ Arthritis	☐ Osteopenia/ Osteoporosis	
☐ Epilepsy/Seizures	☐ Dizziness	☐ Stroke/TIA	
☐ Cancer	☐ Broken/Fractures Bones	☐ Heart Attack	

Please Explain: _____

SURGICAL HISTORY

(Please Check if Applicable)

☐ Pacemaker ☐ Metal/Plastic Implants ☐ Joint Replacement

Any Surgical Procedures:_____

List any Drugs, Medications, or herbal Supplements you are currently taking:

_____

INSURANCE INFORMATION

Do you have health insurance? Yes or No (circle)

Name of Insurance Company: _____

Address: _____

Adjuster's Name: _____ Phone # : _____ Ext: _____

WCB # : _____ Carrier Case # : _____

PAYMENT INFORMATION :

I understand and agree that Health and accident insurance policies are an arrangement between an insurance carrier and me. I also understand that this office will prepare any forms and reports necessary to assist me in making collection from the insurance company and that an amount authorized to be paid directly to the office will be credited to my account on receipt. However I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me or my dependent will be immediatley due and payable.

As a courtesy to our patient we verify your benefits and responsibilities with your insurance company. However, in the case of any miss-quotes, it is still your responsibility to know your insurance responsibilities and payment is expected.

I affirm that the above information is correct to the best of my knowledge.

Patient Signature: _____ Date: _____

Insured Signature: _____ Date: _____

Parent, Spouse, or Guardian Signature: _____ Date: _____