MEDICARE

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 # : _____

Employer : _____ Occupation: _____
Work Address : _____ Phone #: _____
Are you currently working? _____
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
☐ Diabetes	☐ Stroke	☐ High Blood Pressure
☐ TMJ	☐ Arthritis	☐ OTHER
☐ Epilepsy/Seizures	☐ Dizziness	
☐ Cancer	☐ Broken/Fractures Bones	

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: _____

Insured's Name: _____

Insured's Address: _____

Insured's Date of Birth: _____

Relationship to Insured: _____

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

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: _____