Patient Information Form

Name____Date__________________________

Address______________________________________ Date of Birth_______________________

City______________________ State______ Zip__________ SSN Number____________________

Home Phone__________________ Cell Phone___________________ Work Phone______________

Gender M F   Married Y N   Spouses Name ____

Email Address:____

Emergency Contact Name__________________________ Phone Number______________________

Address______________________________ City_________________ State____ Zip___________

Employers Name____ FT PT

Address____ Phone_____________________________

Whom may we thank for referring you to our practice? ____________________________________

Yes No Are you covered by a Group Health Plan through your current or former employment?
Yes No Are you covered by a Group Health Plan through your spouse or other family member's current or former employment?
Yes No Are you receiving Workers' Compensation (WC) benefits?
Yes No Are you filing a claim with a no-fault insurance or liability insurance?
Yes No Are you being treated for an injury or illness for which another party has been found responsible?

<u>INSURANCE</u>

To be filled out if patient is a child or if insurance is through your spouse. If insurance is yours through your employer no need to fill out, we will get all of the information we need from your insurance card.

Name of Insured: ______________________________   Relationship: _____________________

Date of Birth: _________________________________   SSN: ___________________________

Employer: ____

Insurance Company: ____

Patient History Form

Name_______________________________________ Date_______________________

Main Problem

What pain causes you to come to the office? _______________________________

What caused this pain? ____

When did this pain start? ____________________ How long does this pain last? ___________

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain.
Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant

Does this pain travel to any other area? _______________________________
What makes this pain better?_____________________________________
What makes this pain worse?_____________________________________
What else have you done to treat this pain? ___________________________

Other Problem

What other pain do you have? ___________________________________
What caused this pain? ____
When did this pain start? ____________________ How long does this pain last? ___________

How bad is this pain? (Circle the one that applies) Mild, Moderate, Severe, Intolerable

Circle the word or words that best describe the pain.
Cramping, Aching, Dull, Sharp, Shooting, Bright, Diffuse, Lighteninglike, Throbbing, Nagging, Burning, Deep, Stinging, Pressurelike

How often does the pain occur? (Circle the one that applies) Occasional, Frequent, Constant
Does this pain travel to any other area? _____________________________
What makes this pain better? ___________________________________
What makes this pain worse? ___________________________________
What else have you done to treat this pain? _________________________

Allergies Please list any allergies below including allergies to medications.

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____
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Family History

Please tell us about the health of your grandparents, parents, and siblings. Circle or check everything that applies. If someone is deceased, please check or write in the cause.

	Living Deceased	Heart Disease	Stroke	Cancer	Diabetes	Rheumatoid Arthritis	Multiple Sclerosis	Lung Disease
Paternal Grandfather	L D Cause							
Paternal Grandmother	L D Cause							
Maternal Grandfather	L D Cause							
Maternal Grandmother	L D Cause							
Father	L D Cause							
Mother	L D Cause							
Sibling M F	L D Cause							
Sibling M F	L D Cause							
Sibling M F	L D Cause							

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING (Please check Yes or No):

	YES (DATES)	NO		YES (DATES)	NO
HIGH BLOOD PRESSURE			RHEUMATIC FEVER		
AVERAGE BLOOD PRESSURE			MITRAL VALVE PROLAPSE		
LOW BLOOD PRESSURE			HEART MURMUR		
HEART DISEASE			THYROID PROBLEM		
HEART ATTACK			FREQUENTLY TIRED		
CARDIAC PACEMAKER			ANEMIA		
ANGINA			EMPHYSEMA		
SWOLLEN ANKLES			CANCER		
FAINTING/SEIZURES			ARTHRITIS		
ASTHMA			JOINT REPLACEMENT OR IMPLANT		
EPILEPSY/CONVULSIONS			HEPATITIS/JAUNDICE		
LEUKEMIA			SEXUALLY TRANSMITTED DISEASE		
DIABETES			STOMACH TROUBLE/ULCERS		
KIDNEY DISEASES			CHEST PAINS		
AIDS OR HIV INFECTION			EASILY WINDED		
STROKE			HAY FEVER/ALLERGIES		
TUBERCULOSIS			RADIATION THERAPY		
GLAUCOMA			RECENT WEIGHT LOSS/GAIN		
LIVER DISEASE			HEART TROUBLE		
RESPIRATORY PROBLEMS			OTHER		
Taking blood thinners/aspirin daily?			*Women, are you pregnant?*		
Do you use tobacco products? Please list:			*Known allergies to these medications (please circle): Penicillin, Sulfa, "Mycins"?*		
Do you use alcohol, cocaine, other drugs?			*Known allergies to other drugs (please list)?*		
Do you have a history of sleep apnea?			Do you snore?		

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its' contractors or subcontractors, any information needed for this or related Medicare claim.

Signature________________________________ Date________________