PATIENT HISTORY

Date: _____

Last: _____ First _____ Middle _____

Marital Status: S M D W SS: ___ - ___ - ___ Birth Date: _____ Age:

Address: _____ City: _____ State: _____ Zip:

Home Phone #: (___) _____ Work Phone #: (___) _____

Cell Phone (___) _____ E-Mail _____

Patient Employed By: _____ Occupation: _____

Name of Insured: _____ M / F SS: ___ - ___ - ___

HISTORY

What part of your body was injured? _____

Describe how it occurred: _____

Date of Injury: _____

Have you seen any other doctors about this condition? _____

If yes, who? _____ When: _____

Have you had X-rays? Y N When: _____

Are you taking any medications for either the above or any other condition? Y N

If yes, please list: _____

Do you have any allergies to medication? Y N

If yes, please list: _____

Do you have a history of: Diabetes Y N; Heartburn Y N; Ulcers Y N; High Blood Pressure Y N;
Kidney Disease Y N; Liver Disease Y N; Heart Disease Y N; Pregnant Y N;
Do you have any allergies to medications? Y N;
If yes what medications are you taking?
Are you going to therapy? Y N

Height: ___ Ft. ___ In. Weight: ___ lbs.

Patient's or authorized person's signature. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGN _____ DATE	**INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.** SIGN _____