

PATIENT DATA FORM

PATIENT NAME: _____

MARITAL STATUS: M / S

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTH DATE: _____ / _____ / _____ SEX: M / F

HOME #: () _____ WORK #: () _____ CELL#: () _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS _____

CITY _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT NAME: _____ PHONE #: _____

PAYMENT POLICY

Payment is required at the time of service by cash or check. We require the payment directly from you; but we will give you the paperwork needed to get reimbursement you are entitled to depending on the type of insurance carrier that you have. If needed, we will gladly write supporting information to you insurer at no charge to you. Our fee schedule is at your request.

MISSED APPOINTMENTS

Appointments that are cancelled less than twenty-four (24) in advance will be subject to a charge of \$30.00

I UNDERSTAND THE ABOVE PAYMENT AND MISSED APPOINTMENT POLICY.

Patient Signature: _____ Date: _____

MEDICAL QUESTIONNAIRE

Patient Name: _____

Referred by _____

Your Physician: _____

Telephone: _____

Date of last visit: _____

Reason for visit: _____

What problem brings you to our office today? _____

What treatments have you tried previously? _____

Do you have a pacemaker or any artificial joints? Yes No

Operations you have had: Year _____

Diseases you have had requiring hospitalization: Year _____

Serious illness not requiring hospitalization: Year _____

Describe any injuries or accidents you have had: _____

Medications (circle if taken)

Antacids

Antibiotics

Aspirin, Bufferin

Barbiturates

Birth Control Pills

Blood Pressure Pills

Blood Thinning Pills

Cortisone

Cough Medicine

Digitalis

Dilantin

Hormones

Iron or poor Blood Med.

Laxatives

Sleeping Pills

Thyroid Med.

Vitamins

Water Pills

Weight Reduc. Med.

Other _____

Please list any medical conditions not listed: _____

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS CORRECT.

Patient Signature: _____ Date: _____