PATIENT INFORMATION

Patient's Name_____ __Male __Female Date_____
Last First Middle Initial
Mailing Address (Temp) _____
Street City Zip Code
Mailing Address (Perm) _____
Street City Zip Code
Home Phone ( ) _____ Cell ( ) _____ Work ( ) _____
Employer _____
Age ____ Birth date _____Social Security Number _____ Marital Status _____
Who referred you to this office? _____
Reason for Visit_____

RESPONSIBLE PARTY INFORMATION

Name of Responsible Party_____ Relationship to Patient_____
Address_____
Street City Zip Code
Home Phone ( ) _____ Cell ( ) _____ Work ( ) _____
Employer Name and Address _____
Social Security Number _____ Age _____ Birth Date _____
Nearest Relative not living with you_____Relation_____Phone ( )_____

INSURANCE INFORMATION

Please complete the insurance section applicable to you. We will also need to make a copy of your insurance card.

Primary Insurance responsible for Payment_____
Is this Ins a PPO Plan? _____ or HMO Plan? _____ Pre-Approval Number_____
Insurance Company Address_____
When did this insurance become effective?_____
Employer's Phone_____
Insured Party Policy #_____ Group #_____
Relationship to Patient_____
Primary Care Physician_____ Phone #_____

Secondary Insurance responsible for Payment_____
Is this Ins a PPO Plan? _____ or HMO Plan? _____ Pre-Approval Number_____
Insurance Company Address_____
When did this insurance become effective?_____
Employer's Phone_____
Insured Party Policy #_____ Group #_____
Relationship to Patient_____
Primary Care Physician_____ Phone #_____

Industrial_____
Employer Name and Address_____
Employers Phone _____ Industrial Ins Carrier_____
Carrier's Address_____
Accident Date_____Claim #_____
Pre-Approval_____
(MRI, CT, Surgery, etc)
AHCCCS or Foster Care Plan Name_____ ID#_____
Primary Care Physician_____ Phone ( )_____ Pre-Approval _____

The above information is correct to the best of my knowledge.
Signed_____ Date_____

Please read the following Authorization and sign at the bottom.

I authorize my holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, or my private insurance carrier, any information needed for this or a related claim. I permit a copy of the authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I authorize the doctor to bill all services and allow my insurance carrier to issue indemnity payments directly to the physician. I understand that any services not covered by insurance are the responsibility of the responsible party.

_____ _____

Signature of Patient Date Signature of Responsible Party Date

Medical History

Name of Patient_____

Please describe the main reason for your visit._____

Which side is affected? Right Left Both (Please circle appropriate answer.)
Height_____ Weight_____ Age_____

Did your problem occur as a result of an accident or injury? Yes No

Date of Injury/ or when problem started?_____ Did the injury occur at work? Yes No

What is your occupation?_____

Are you right or left handed?_____ Drug Allergies:_____

Have you ever been diagnosed with any of the following medical problems?

	YES	NO	DETAILS
HIGH BLOOD PRESSURE			
DIABETES			
RHEUMATOID ARTHRITIS			
DEGENERATIVE ARTHRITIS			
CANCER			
EYE DISEASE			
EAR, NOSE, OR THROAT DISEASE			
LUNG DISEASE			
ASTHMA			
EMPHYSEMA			
THYROID DISEASE			
HEART DISEASE			
HAVE YOU HAD A HEART ATTACK?			
DO YOU HAVE CHEST PAIN?			

	YES	NO	DETAILS
DO YOU HAVE PALPITATIONS?			
LIVER/ KIDNEY DISEASE			
STOMACH OR INTESTINAL DISEASE			
NUEROLOGICAL DISEASE			
HAVE YOU HAD A STROKE?			
DO YOU HAVE SEIZURES?			

Any Medical Problems and/or information we should know?

_____

_____

Do you drink alcoholic beverages? YES NO
Quantity_____

Do you smoke? YES NO
Quantity_____
How long?_____

List ALL Medications you currently take.

Medication Name	Dose	How Often

Have you ever been hospitalized? If yes, please list dates, what facility and reason for admission.

Date	Facility	Reason

Have you ever had surgery? If yes, please list date, facility, and type of surgery.

Date	Facility	Surgery/Procedure