CONFIDENTIAL PATIENT INFORMATION

NAME ____
First   Middle   Last

ADDRESS ____
Street   City   Zip Code

MOBILE PHONE ____________________________________ WORK PHONE ______________________________

EMAIL ____

AGE __________ DATE of BIRTH ____________ SEX _______ MARITAL STATUS M S D W

SOCIAL SECURITY NO________________________________ CA LICENSE NO.______________________________

OCCUPATION ____

EMPLOYER & ADDRESS ____

NEAREST RELATIVE NOT LIVING WITH YOU____________________ PHONE _______________________________

ADDRESS ____
Street   City   State   Zip Code

IN CASE OF AN EMERGENCY CALL:

____
Name   Phone

FOR WOMEN: Are you pregnant?____________ If yes, how far along?_______________________________

FOR MINORS: List both parents' names and addresses

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FINANCIAL ARRANGEMENTS

HOW DO YOU PLAN TO HANDLE YOUR ACCOUNT? Check One: [ ] Cash [ ] Check

INSURANCE INFORMATION

Do you have personal, group health, or accident insurance? If yes, give:

COMPANY NAME____

ADDRESS____

SUBSCRIBER NAME______________________________________ GROUP NO. ______________________________

CASE HISTORY

CHIEF COMPLAINT____

COMPLAINT RESULT OF: Auto Accident _________ Injury ________ Job Related ________ Other _____________________

DATE of ACCIDENT/ INJURY / OTHER ____

HAVE YOU SEEN ANOTHER DOCTOR ABOUT THIS CONDITION? IF YES, WHEN?_______________________________

NAME of DOCTOR_________________________ ADDRESS____

HAVE YOU HAD RECENT X-RAYS, MRI? IF YES, WHEN?____________ AREA?______________________________

OTHER HEALTH INFORMATION YOU WOULD LIKE TO SHARE ____

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I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statures, for the care and management of this complaint.

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DATED   PATIENT'S SIGNATURE   (parent's signature if patient is a minor)