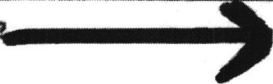


Practice: _____

Today's Date: _____

Name: _____ DOB: _____ Chart Number: _____
 Sex: M F Marital Status: Single Married Widowed Divorced SS#: _____
 E-mail: _____ Spouse/Partner Name: _____
 E-mail newsletters, reminders, statements, etc. Emergency Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home #: _____ Cell #: _____ Other #: _____
 Employer: _____ Phone: _____
 Employer Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Are you the insured? Yes No
Insured Information
 Subscriber Name: _____ Relationship to insured: Spouse Child Self other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____
 Secondary Insurance: _____ Are you the insured? Yes No
Insured Information
 Subscriber Name: _____ Relationship to insured: Spouse Child Self Other
 Phone #: _____ Sex: Male Female DOB: ___/___/___
 Address: _____
 Policy ID: _____ Group ID: _____ Employer: _____

How did you find out about our practice? 
 Internet
 Senior Blue Book
 Church Bulletin
 Referral
 Friend Doctor Family

 What is the reason for your visit today? _____
 Result of accident or work injury? Yes No
 How long has this bothered you? 1 2 3 4 5 6 7 days weeks months years
 What treatments have you tried & have they been effective? _____
 On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10
 The pain quality is: burning constant dull sharp shooting throbbing tingling Other: _____

PLEASE READ AND SIGN

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____

Date: _____

1000