WHAT'S NEW!?

Date:____________ E-Mail:__________________________ Cell Phone: (____)______________

Name ____ Home Phone:(____)____________

Address:_____________________________ City:___________________ State:______ Zip:______________

Occupation:____________________ Employer:____________________Work Phone:(____)______________

Occupation Address:____
Street City State Zip

[ ] Single [ ] Married [ ] Other Spouses Name:____________________________

___ I am interested in a no-interest payment plan to cover any costs associated with treatment.

Insurance Information

Name of Health Insurance Company:____

Subscriber # ___________________________________ Group # ________________________________

Insurance Holder's Name:_____________________ Date of Birth:___/___/____. SSN:______________

Insured's Employer____

Relationship to You: [ ] Self [ ] Spouse [ ] Mother [ ] Father

Is this complaint due to a work related or auto accident: YES / NO

Any time lost from work due to this illness or accident: YES / NO From:_______ To:________

Signing below verifies your consent to the rendering of care including treatment and performance of diagnostic procedures.

Patient Signature:_______________________________________ Date:_____________

If Minor, Parent/Guardian Signature of Consent:_________________________________ Date:____________

Office Witness:____ Date:_________________ Acct:_______

CASE HISTORY FORM

PLEASE INDICATE **Y** (YES) OR **N** (NO) FOR ALL SYMPTOMS/CONDITIONS
YOU CURENTLY HAVE OR HAVE HAD IN THE PAST.

[ ] Y [ ] N Pneumonia
[ ] Y [ ] N Rheumatic Fever
[ ] Y [ ] N Polio
[ ] Y [ ] N Tuberculosis
[ ] Y [ ] N Whooping Cough
[ ] Y [ ] N Diabetes
[ ] Y [ ] N Cancer
[ ] Y [ ] N Heart Disease
[ ] Y [ ] N Thyroid
[ ] Y [ ] N Arthritis
[ ] Y [ ] N Epilepsy
[ ] Y [ ] N Mental Disorders
[ ] Y [ ] N Nervous
[ ] Y [ ] N Numbness
[ ] Y [ ] N Paralysis
[ ] Y [ ] N Dizziness
[ ] Y [ ] N Are you HIV positive

[ ] Y [ ] N Forgetfulness
[ ] Y [ ] N Headaches
[ ] Y [ ] N Confusion/ Depression
[ ] Y [ ] N Fever
[ ] Y [ ] N Tingling Extremities
[ ] Y [ ] N Fainting Convulsions
[ ] Y [ ] N Fatigue
[ ] Y [ ] N Loss of Sleep
[ ] Y [ ] N Poor/Excessive Appetite
[ ] Y [ ] N Excessive Thirst
[ ] Y [ ] N Frequent Nausea
[ ] Y [ ] N Vomiting
[ ] Y [ ] N Diarrhea
[ ] Y [ ] N Constipation
[ ] Y [ ] N Loss of Bowel Control
[ ] Y [ ] N Are You Pregnant?

[ ] Y [ ] N Abdominal Cramps
[ ] Y [ ] N Black/Bloody Stool
[ ] Y [ ] N Loss of Bladder Control
[ ] Y [ ] N Discolored Urine
[ ] Y [ ] N Painful/Excessive Urination
[ ] Y [ ] N Chest Pain
[ ] Y [ ] N Short Breath
[ ] Y [ ] N Blood Pressure
[ ] Y [ ] N Problems
[ ] Y [ ] N Irregular Heartbeat
[ ] Y [ ] N Heart Problems
[ ] Y [ ] N Lung Problems
[ ] Y [ ] N Congestion
[ ] Y [ ] N Stroke
_____________ When was your last Menstrual period?

Do you smoke? [ ] Y [ ] N
How much? _______________

Do you drink alcohol? [ ] Y [ ] N
How much? _____________________

Do you do recreational drugs? [ ] Y [ ] N
How much? ____________________________

Who is your primary care/medical doctor? ____

Location: ____ Telephone: _________________

Have you had any surgeries? [ ] Y [ ] N
Please List:
____
____
____

Are you currently taking any prescription drugs? [ ] Y [ ] N

Please List:
____
____
____

Dr. Signature ____ Date ______________

Patient Name:____ DOB:_______________ Pt. Acct. #:__________