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

CONSTITUTIONAL

- ☐ DENY ALL
- ☐ CHILLS
- ☐ FAINTING
- ☐ FATIGUE
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ WEAKNESS
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

INTEGUMENTARY

- ☐ DENY ALL
- ☐ ECZEMA
- ☐ HAIR GROWTH
- ☐ HAIR LOSS
- ☐ HIVES
- ☐ ITCHING
- ☐ PARESTHESIA
- ☐ RASH
- ☐ SKIN LESIONS

PSYCHIATRIC

- ☐ DENY ALL
- ☐ AGITATION
- ☐ ANXIETY
- ☐ APPETITE CHANGES
- ☐ BEHAVIORAL CHANGES
- ☐ BIPOLAR DISORDER
- ☐ CONFUSION
- ☐ DEPRESSION
- ☐ HOMICIDAL INDICATION
- ☐ INSOMNIA
- ☐ MEMORY LOSS
- ☐ SUBSTANCE ABUSE
- ☐ SUICIDAL INDICATION

EYES

- ☐ DENY ALL
- ☐ BLURRED VISION
- ☐ CATARACTS
- ☐ CHANGE IN VISION
- ☐ DOUBLE VISION
- ☐ DRY EYES
- ☐ GLAUCOMA
- ☐ SENSITIVITY TO LIGHT
- ☐ TEARING

GASTROINTESTINAL

- ☐ DENY ALL
- ☐ ABDOMINAL PAIN
- ☐ BLACK, TARRY STOOLS
- ☐ CONSTIPATION
- ☐ DIARRHEA
- ☐ HEARTBURN
- ☐ HEMORRHOIDS
- ☐ INDIGESTION
- ☐ NAUSEA
- ☐ RECTAL BLEEDING
- ☐ VOMITING

ALLERGIC/IMMUNOLOGIC

- ☐ DENY ALL
- ☐ HISTORY OF ANAPHYLAXIS
- ☐ ITCHY EYES
- ☐ SNEEZING

HEMATOLOGIC/LYMPHATIC

- ☐ DENY ALL
- ☐ ANEMIA
- ☐ BLEEDING
- ☐ BLOOD CLOTTING
- ☐ BLOOD TRANSFUSIONS
- ☐ BRUISE EASILY
- ☐ LYMPH NODE SWELLING

MUSCULOSKELETAL

- ☐ DENY ALL
- ☐ ARTHRITIS
- ☐ NECK PAIN
- ☐ DECREASED MOTION
- ☐ GOUT
- ☐ INJURIES
- ☐ JOINT PAIN
- ☐ BACK PAIN
- ☐ MUSCLE CRAMPS
- ☐ MUSCLE PAIN
- ☐ MUSCLE WEAKNESS
- ☐ SWELLING

CARDIOVASCULAR

- ☐ DENY ALL
- ☐ ANGINA
- ☐ CHEST PAIN
- ☐ HEART MURMUR
- ☐ HEART PROBLEMS
- ☐ HIGH BLOOD PRESSURE
- ☐ LOW BLOOD PRESSURE
- ☐ PALPITATIONS
- ☐ SHORTNESS OF BREATH
- ☐ SWELLING OF LEGS
- ☐ VARICOSE VEINS

GENITOURINARY

- ☐ DENY ALL
- ☐ BURNING URINATION
- ☐ CRAMPS
- ☐ FREQUENT URINATION
- ☐ HESITANCY/DRIBBLING
- ☐ HORMONE THERAPY
- ☐ IRREGULAR MENSTRUATION
- ☐ LACK OF BLADDER CONTROL
- ☐ PROSTATE PROBLEMS
- ☐ URINE RETENTION
- ☐ VAGINAL BLEEDING
- ☐ VAGINAL DISCHARGE

ENDOCRINE

- ☐ DENY ALL
- ☐ DIABETES
- ☐ EXCESSIVE APPETITE
- ☐ EXCESSIVE HUNGER
- ☐ EXCESSIVE THIRST
- ☐ GOITER
- ☐ HAIR LOSS

NEUROLOGICAL

- ☐ DENY ALL
- ☐ CHANGE IN CONCENTRATION
- ☐ CHANGE IN MEMORY
- ☐ DIZZINESS
- ☐ HEADACHE
- ☐ IMBALANCE
- ☐ LOSS OF CONSCIOUSNESS
- ☐ LOSS OF MEMORY
- ☐ NUMBNESS/TINGLING
- ☐ SEIZURES
- ☐ SLEEP DISTURBANCE
- ☐ SLURRED SPEECH
- ☐ STRESS
- ☐ STROKES
- ☐ TREMORS

RESPIRATORY

- ☐ DENY ALL
- ☐ ASTHMA
- ☐ BRONCHITIS
- ☐ DRY COUGH
- ☐ PRODUCTIVE COUGH
- ☐ COUGHING UP BLOOD
- ☐ DIFFICULTY BREATHING
- ☐ PNEUMONIA
- ☐ SPUTUM PRODUCTION
- ☐ WHEEZING

ENMT

- ☐ DENY ALL
- ☐ BAD BREATH
- ☐ DENTURES
- ☐ DIFFICULTY SWALLOWING
- ☐ EAR DRAINAGE
- ☐ EAR PAIN
- ☐ FREQUENT SORE THROATS
- ☐ HEAD INJURY
- ☐ HEARING LOSS
- ☐ HOARSENESS
- ☐ LOSS OF SMELL
- ☐ LOSS OF TASTE
- ☐ NASAL CONGESTION
- ☐ NOSE BLEEDS
- ☐ SINUS INFECTIONS
- ☐ RUNNY NOSE
- ☐ SNORING
- ☐ SORE THROAT
- ☐ RINGING IN EARS

PATIENT NAME: DOB: ACCT #:

DOCTOR SIGNATURE: _____

PERSONAL HISTORY FORM

1. Do you smoke? Yes No How much? _____
2. Do you drink alcohol? Yes No How much? _____
3. Do you do any recreational drugs? Yes No How much? _____
4. Do you exercise? Yes No How much? _____
5. Are you pregnant, or any chance of being pregnant? (Female Only) Yes No How far along? _____

Who have you seen as your primary care/medical doctor?
_____

Location: _____Telephone: _____

Past Hospitalizations: (list date and reason)
___/___/___/ _____
___/___/___ _____
___/___/___ _____

Past Surgeries: (list date and reason)
___/___/___ _____
___/___/___ _____
___/___/___ _____

Past Fractures: (list date and reason)
___/___/___ _____
___/___/___ _____
___/___/___ _____

List any chronic diseases you may have: _____
_____

Are you currently taking any prescription drugs? [ ] Y [ ] N
Please list:
_____ _____
_____ _____

Dr. Signature: _____ Date: _____

Patient Name: _____ DoB: _____ Pt. Acct #:_____