

NEW PATIENT INFORMATION

PATIENT INFORMATION			Date _____ / _____ / _____
Name: _____	LAST	FIRST	S.S. # _____ - _____ - _____
Address: _____		City: _____	State: _____ Zip: _____
Home Phone: (____) _____	Work Phone: (____) _____	Cell: (____) _____	
Email: _____	Occupation: _____	Employer: _____	
Work Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Off-Work <input type="checkbox"/> Student			
Date of Birth: _____ / _____ / _____		Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Children: <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____			
Spouse's Name: _____		Phone: (____) _____	
Spouse's Employer: _____		Phone: (____) _____	
Emergency Contact: _____		Phone: (____) _____	
Whom may we thank for referring you? _____			

INSURANCE / PAYMENT INFORMATION	
Is your injury / illness <u>work related</u> ? <input type="checkbox"/> YES <input type="checkbox"/> NO	
If yes, have you reported the injury to your employer? <input type="checkbox"/> YES <input type="checkbox"/> NO Date of injury: _____ / _____ / _____	
Is your injury / illness related to an <u>automobile accident</u> ? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please complete the following:	
Your auto insurance company name and address: _____	

Claim #: _____	Policy #: _____
Attorney name and address: _____	

Do you have <u>health insurance</u> ? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please complete the following:	
1. Primary insurance company name: _____	
Address: _____	
Insured's Name: _____	ID #: _____ Group #: _____
2. Secondary insurance company name: _____	
Address: _____	
Insured's Name: _____	ID #: _____ Group #: _____

ASSIGNMENT AND RELEASE		
I, the undersigned assign directly to Spine & Sports Institute all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Spine & Sports Institute to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions and/or requests pertaining to my physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions.		
_____	_____	_____ / _____ / _____
RESPONSIBLE PARTY SIGNATURE	RELATIONSHIP	DATE

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheum. Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ringing in Ears	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ankle Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Balance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Sleep	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding		Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid	
Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Multiple		Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel/Bladder		General		Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Lump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unintentional	
Chemical		Gonorrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Change	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gout	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vaginal	
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pins / Needles		Veneral	
Cold Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Feeling in Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Visual Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herniated Disc	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate		Other	_____
Digestive		High		Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking Packs / Day _____
 Alcohol Drinks / Week _____
 Caffeine Cups / Day _____
 High Stress Reason _____

Are you pregnant? YES NO Due Date _____

INJURIES / SURGERIES / ACCIDENTS

Description

Date

Falls: _____	_____
Head Injuries: _____	_____
Broken Bones: _____	_____
Dislocations: _____	_____
Surgeries (Including Cosmetic): _____	_____
Automobile Accidents: _____	_____

MEDICATIONS

ALLERGIES

VITAMINS / HERBS / SUPPLEMENTS

_____	_____	_____
_____	_____	_____
_____	_____	_____