



WELCOME TO OUR OFFICE
CONFIDENTIAL PATIENT RESPONSIBILITY AND INTAKE

ABOUT YOU

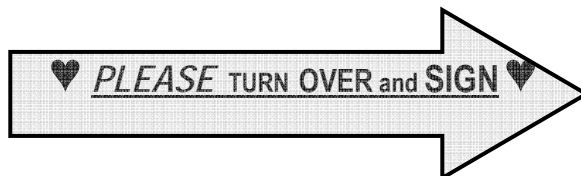
Patient's Last Name		First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Relationship Status:		
				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
				<input type="checkbox"/> Dr.	<input type="checkbox"/> Att.	<input type="checkbox"/> Separated	<input type="checkbox"/> Widowed	<input type="checkbox"/> Partnered
Is this your legal name?	If not, what is your legal name?		Nickname?		Birth Date	Age	Sex	
<input type="checkbox"/> Yes <input type="checkbox"/> No							<input type="checkbox"/> M <input type="checkbox"/> F	
Street Address			City	State	ZIP Code			
Social Security Number			E-mail -- MyName@XXX.com		Home/Contact Phone No.		Mobile #	
					()		()	
Occupation		Employer			Employer Phone No.			
					()			
Who should we THANK for referring you (Please check box(s)) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital								
<input type="checkbox"/> Family <input type="checkbox"/> Friend Who: _ _____ <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper _____ Other: _____								
Other Family Members Seen Here _____								

INSURANCE INFORMATION ■ PLEASE GIVE US YOUR *INSURANCE CARD* AND/OR *LEGAL ID*

Person Responsible for Bill		Birth Date	Address (if different than above)		Home Phone No.	
					()	
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation		Employer	Employer Address		Employer Phone No.	
					()	
Is this patient covered by insurance? Primary <input type="checkbox"/> Yes <input type="checkbox"/> No Name: _____						
<input type="checkbox"/> [Insurance] SECONDARY- _____				<input type="checkbox"/> Other _____		
Subscriber's Name		Subscriber's Social Security #	Birth Date	Group #	Policy #	Co-Payment
						\$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____						
Name of Secondary Insurance (if applicable)			Subscriber's Name		Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____						

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)		Relationship to Patient	Home/Contact Phone No.	Work Phone No.
			()	()



REASON FOR VISIT

Reason for visit? School Physical CDL-Truck Physical FAA-Pilot Physical Pre-Operative Weight Loss Pain Treatment/Management

Please list your health symptoms, problems or concerns: _____

Please describe pain and location: _____ Is it constant: Yes No Comes and goes Yes No

Is it getting worse? Yes No

Have you had same or similar in the past? Yes No When did it begin-estimate/Approximately? _____

How did it happen? _____

MEDICAL HISTORY

Please list **any Past Accidents** with dates: _____

When was your **last** physical exam? ____ / ____ / ____ Physician's Name: _____ Phone: (____) _____

1. Are you currently under medical treatment..... Yes No Please describe: _____

2. Have you had any serious illnesses or Surgeries/Operations? Yes No Please Describe _____

3. Are you taking any MEDICATION(S)? Yes No If yes what _____

4. Do you SMOKE? Yes No How much? _____ Gum/Teeth/Mouth Decay? Yes No Foot/Leg Pain? Yes No

5. Do you use alcohol? Yes No What? _____ How much? _____

6. Do you use cocaine, ecstasy or **any** other drugs Yes No What? _____

7. Have you had any **ALLERGIC** reactions to the following (check Box): Local Anesthetics (e.g. Novocain) Penicillin of other Antibiotics
 Sulfa Drugs Barbiturates (sleeping pills) Sedatives Iodine Aspirin Other Describe: _____

8. Hospitalizations Yes No Date(s): _____ Reason(s): _____

Women Only:

Do you have regular periods? Yes No Are you pregnant? Yes No Are you taking birth control? Yes No

Have you ever been pregnant? Yes No Number of pregnancies: _____ Have you ever miscarried? Yes No if yes # miscarriages _____

Have you ever had the following?

- | | | | | | |
|--|----------------------------|--|--------------------------------|--|-------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Attack/Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Surgery/ Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapsed | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial valves |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostrate Problems (men) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles/skin ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Frequent Neck Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema/Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High/Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe/ frequent headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney problems/Stones | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers Colitis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting/Seizures/Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma/Wheezing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes/Low Blood Sugar | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty Breathing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chemotherapy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Lower Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Artificial Bones Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia/Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression/Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic fatigue | <input type="checkbox"/> Yes <input type="checkbox"/> No | Crack/Cocaine/Ecstasy Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heroin |

Please list any other serious medical condition(s) you have ever had: _____

Assignment and Release

- We invite you to discuss with us any question regarding all our services. The best health services are based on friendly mutual understanding between provider and patient.
- Our Policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- It is my responsibility to notify this office of any change in my medical status.
- I also authorize Americare Health or insurance company to release any information required to process my claims.
- The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for any balance.

X

SIGNATURE

PATIENT / GUARDIAN

DATE



THANK YOU!! PLEASE RETURN TO AN OFFICE TEAM MEMBER



"WE SERVE YOU"