(Please print legibly)

PATIENT NAME_____ DATE OF BIRTH_____

ADDRESS_____ SOCIAL SECURITY #_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ WORK PHONE_____

ALTERNATE PHONE_____ (Please circle) MALE/FEMALE Marital Status S M D W

REFERRED BY_____

(Please circle type of tests performed) CT SCAN MRI XRAY EMG OTHER

WHERE PERFORMED_____

PATIENTS EMPLOYER_____ ADDRESS_____

_____

EMERGENCY CONTACT_____ RELATIONSHIP_____

ADDRESS_____ PHONE #_____

INSURANCE INFORMATION: (Please Circle) HMO PPO PRIVATE CASH MEDICARE

Carrier #1_____ Phone #_____

Mailing Address_____

Guarantor_____ Birthdate_____

Relationship_____ ID#_____ Group#_____

Carrier #2_____ Phone #_____

Mailing Address_____

Guarantor_____ Birthdate_____

Relationship_____ ID#_____ Group#_____

I HEREBY AUTHORIZE THE PHYSICIAN TO FURNISH MY INSURANCE COMPANY WITH ANY INFORMATION NEEDED TO PROCESS MY CLAIM. I ALSO AUTHORIZE PAYMENTS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL NOT AUTHORIZED AND NON-COVERED SERVICES.

SIGNATURE_____ DATE_____

MEDICAL HISTORY

DATE_____PATIENT NAME_____ AGE_____

HT ____ '____ " WT_____ (Please Circle) MALE/FEMALE MARRIED/SINGLE LEFT/RIGHT-HANDED

TYPE OF WORK YOU DO_____

WHAT PROBLEM(S) BRING YOU TO THE DOCTOR_____

WHEN DID THE PROBLEM(S) START_____IS/ARE PROBLEM(S)GETTING WORSE_____

WAS THERE AN ACCIDENT OR INJURY_____WAS IT WORK-RELATED_____

WHAT DOCTORS HAVE YOU SEEN FOR THE PROBLEM(S) _____

HAVE YOU EVER BEEN HOSPITALIZED_____DATE(S)_____ WHERE_____
_____ _____

LIST SURGERIES YOU HAVE HAD AND DATES_____
_____

LIST ANY MAJOR ILLNESSES YOU HAVE_____

LIST ALL MEDICATIONS (WITH DOSE) YOU ARE PRESENTLY TAKING_____
_____

LIST ANY ALLERGIES TO MEDICATIONS_____

ARE THERE ANY DISEASES WHICH RUN IN YOUR FAMILY_____

DO YOU SMOKE_____HOW MANY PER DAY_____

DO YOU DRINK ALCOHOLIC BEVERAGES_____HOW MUCH_____ HOW OFTEN_____

WHEN WAS YOUR LAST CHEST XRAY_____EKG_____BLOOD TESTS_____

PLEASE "X" IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

_____HEART ATTACK	_____HEART PROBLEMS	_____HIGH BLOOD PRESSURE
_____STROKE	_____SEIZURES	_____BLEEDING DISORDER
_____DIABETES	_____ANY LUNG PROBLEMS	_____ASTHMA
_____EMPHYSEMA		

PATIENT SIGNATURE_____