Patient Demographic Form
(Please Print)

Patient Information

Patient Name: _____ _____**Date of Birth**: ____ / ____ / ____ **Sex**: □ M □ F
Last First

Home Address: _____ **City:** _____ **State:** _____ **Zip**: _____

SSN #: _____ - ____ - _____ **Home #:** (_____) _____ - _____ **Cell #:** (_____) _____ - _____

Work #: (_____) _____ - _____ **Ext #**: _____ **E-Mail**: _____

Primary Language: _____ **Race/Ethnicity**: _____
□ Prefer not to report

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Employer: _____ **Occupation**: _____

Do you have a legal guardian or healthcare power of attorney? □ Yes □ No

If Yes, Name: _____ **Relationship**: _____ **Phone #:** (_____) _____ - _____

Emergency Contact: _____ **Relationship:** _____**Phone #**: (_____) _____ - _____

Primary Care Doctor: _____**Who referred you to us?** _____

Pharmacy: _____ **Location:** _____**Phone #**: (_____) _____ - _____

Is there a family member or other person you would like for us to share your medical information?

□ Yes **Name(s)**_____
□ No

Insurance Information

Company: _____

Insured's Name: _____ **Insured's Date of Birth**: ____ / ____ / _____

Insured's SSN #: _____ - _____ - _____

Current Problem

What specific problem brings you to our office today? _____

How long ago did this problem first start? _____ Days / Weeks / Months / Years

How would you describe your pain? □ No Pain □ Sharp □ Dull □ Aching □ Burning □ Radiating

□ Itching □ Stabbing □ Other: _____

How would you rate your pain on a scale from 0 to 10? (Please circle)

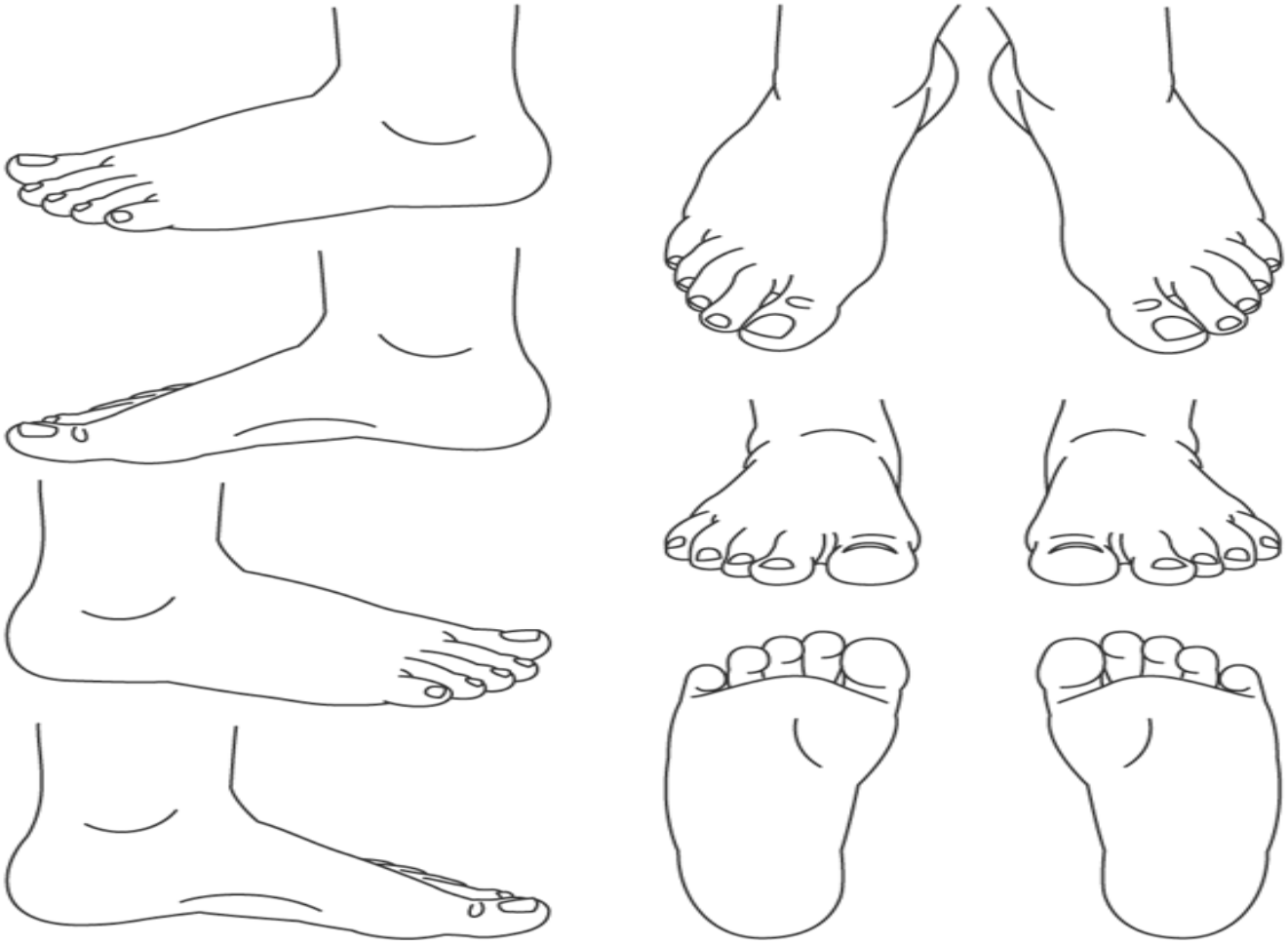
(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain possible)

What treatments have you had for this problem? _____

Was this problem cause by an injury? □ Yes (describe) _____
□ No

If Yes, was this a work related injury? □ Yes
□ No

Where is the pain / problem located? Please mark on the pictures below:



Medical History

Allergies: _____ □ **None Known Drug Allergies**

Are you a current smoker? □ Yes □ No
If no, Have you ever smoked? □ Yes □ No
If yes, What was the date of your last cigarette? _____

Have you had a Flu Shot since September 1st: □ Yes □ No **When?** _____
Patient over 65 have you hadx a Pneumonia shot? □ Yes □ No **When?**_____
Have you ever had any of the following?

Anemia	Y	N	Fibromyalgia	Y	N	Neuropathy	Y	N
Arthritis	Y	N	Gout	Y	N	Open Sores	Y	N
Asthma	Y	N	Heart Attack	Y	N	Pneumonia	Y	N
Abnormal Bleeding	Y	N	Hepatitis	Y	N	Skin Disorder	Y	N
Blood Clots	Y	N	HIV+/AIDS	Y	N	Stomach Ulcers	Y	N
Blood Transfusion	Y	N	High Blood Pressure	Y	N	Stroke	Y	N
Cancer	Y	N	Kidney Disease	Y	N	Thyroid Disease	Y	N
Diabetes	Y	N	Liver Disease	Y	N	Tuberculosis	Y	N
			Are you currently under Pain Management care?	Y	N	Have you been under Pain Management care in the past?	Y	N
Low Blood Pressure	Y	N						

If yes, please list Pain Management Doctor: _____ **Phone#:** _____

Height:_____ **Weight:**_____ **Shoe Size**:_____

Please List all prior Surgeries:

Type of Surgery	Date	Type of Surgery	Date
_____		_____	
_____		_____	
_____		_____	

Please list all prior hospitalizations (Other than for Surgery)

Reason for hospitalization	Date	Reason for hospitalization	Date
_____		_____	
_____		_____	
_____		_____	

Please list all medications you are currently taking:

Name	Dose	How often do you take them?

Family History

Mother: Alive/Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer □ Arthritis
Father: Alive/Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer □ Arthritis
Sibling: Alive/Deceased □ Diabetes □ Hypertension □ Heart Disease □ Stroke □ Mental Illness □ Cancer □ Arthritis

Please be prepared to present your current insurance card(s) and driver's license at your initial visit and periodically throughout your time at the office.

- It is your responsibility to supply all current insurance and demographic information.
- Failure to properly inform us of any insurance changes will result in patient being responsible for any unpaid balances.
- Please note that while we verify your insurance benefits, verification of benefits is not a guarantee of payment.

It is your responsibility to understand the terms and conditions of your (or the insured) insurance coverage including in-network/out-of-network, co-payment, and co-insurance responsibilities, benefit maximum and non-covered services.

- It is understood that your insurance company may not pay for the total bill for the care received.
- If your insurance requires a referral, you are expected to be responsible for obtaining them unless we tell you otherwise.
- Your visit may need to be rescheduled if there is not a proper referral at the time of your visit, as we are unable to get referrals after you have been seen.

In the event that my insurance company denies payment to us, or no insurance coverage is available to me, I agree that I will assume responsibility for payment of my account.

- Payment for services is due at the time of your visit. This may include co-payments, co-insurance, deductible, and amounts for services that may not be covered by your insurance company.
- Should you not fulfill your financial obligations at the time service is rendered, your service may be rescheduled as medically appropriate to allow you to make necessary financial arrangements.

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____

Print name of patient, Parent/Guardian

_____

If other than patient, relationship to patient

_____

Signature & Date

Authorizations

Benefits to Physician and Release of Information:

□ Yes □ No I hereby authorize payment directly to the physician of the surgical and/or medical benefits.

□ Yes □ No I also understand I am responsible for any portion of my bill not covered by my insurance company.

□ Yes □ No The information authorized for release may include information which may be considered a communicable or venereal disease, including hepatitis, syphilis, gonorrhea, HIV and AIDS.

Date: ____ / ____ / _____ Signature: _____ Guardian: _____

Acknowledgement of receipt of notice of Privacy Practices:

I acknowledge that I was provided a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read if I so chose) and understand the notice.

Date: ____ / ____ / _____ Signature: _____ Guardian: _____