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First Name:	Last Name:	Date Of Birth:
 Home Phone:	 Mobile Phone:	 Work Phone:
@E-Mail:	Preferred Communication:	(Circle)  H  M  W  E@
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

SSN:	Gender: <input type="checkbox"/>  Female <input type="checkbox"/>  Male	Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other _____
Race & Ethnicity: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Emergency Contact Name:	 Phone:	Relationship:

Primary Care Provider Name:	 Phone:
Street Address:	Apt/Suite #:
City:	ZipCode: State:

Employer/Company Name:	 Phone:
Street Address:	Apt/Suite #:
City:	ZipCode: State:
Job Title/Position:	Currently Working: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Date Stopped Working:

# Insurance Detail

## Primary Insurance Coverage

Insurance Company Name:	Policyholder Name:	
Insurance ID #:	Group Number:	
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
<b>(Office Use)</b> Policy Effective Date(s):	Payer ID:	
Co-Pay \$:	Co-Insurance %:	Deductible:

## Secondary Insurance Coverage

Insurance Company Name:	Policyholder Name:	
Insurance ID #:	Group Number:	
Plan Name:	Phone Number:	
Street Address:	Suite/Unit #:	
City:	ZipCode:	State:
<b>(Office Use)</b> Policy Effective Date(s):	Payer ID:	
Co-Pay \$:	Co-Insurance %:	Deductible:

## Financially Responsible Party

<input type="checkbox"/> Self	<input type="checkbox"/> Other (If Other Please Complete Section Below)	
First Name:	Last Name:	Date Of Birth:
Home Phone:	Mobile Phone:	Work Phone:
@ E-Mail:	Relationship With Patient:	
Street Address:	Apt/Suite #:	
City:	ZipCode:	State:

# Medical Detail

	MM	DD	YYYY	
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## Reason For Your Visit

Wellness & Health Maintenance

Injury, Pain Complaint, or Ailment

Date Of Injury (When Did Your Pain Start?)

Accident

- Automobile Related Accident  
 Other Type Of Accident

Date Of Accident:

MM/DD/YYYY

State: Where Accident Occurred

MM/DD/YYYY

Please Provide Brief Details Of Your Injuries & Pain:

## Referring Provider

I Was Referred By My Primary Care Physician (Same Doctor Listed On First Page)

I Was Referred By Another Doctor (Please Fill Out Doctor Info Below)

Referring Provider Name:

 Phone:

Street Address:

Apt/Suite #:

@ E-Mail:


City:

ZipCode:

State:

## Representative Details (If You Are Being Represented By An Attorney For An Accident Please Provide Info)

Referring Provider Name:

 Phone:

Street Address:

Apt/Suite #:

@ E-Mail:

City:

ZipCode:

State:

# Medical History

## Lifestyle

  MM  DD  YYYY 

Are You A Smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes ⇨ How Often? _____ /Day /Week
Do You Drink Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes ⇨ How Often? _____ /Day /Week
Do You Exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes ⇨ How Often? _____ /Day /Week

Have You Ever Been Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have You Had Any Surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Please List Dates/Details:	

Do You Have Any Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	⇨ Do You Require Medical Treatment For Your Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, Please Provide Details:	

Do You Take Any Medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Please List All Medications & Dosage (How Much & How Often?)

Please Provide Any Other Medical Information You Feel The Doctor Needs To Know About

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Patient Signature

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Date