Patient Information Sheet

CONFIDENTIAL

Patient Information

Last Name: _____ S.S. #: _____

First Name: _____

Address: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

Email: _____

Do you want to receive email notifications before appointments? ☐Yes ☐No

Birth Date (MM/DD/YY): _____ Sex: ☐Male ☐Female

Height: _____ Weight: _____

Occupation: _____

Employment status (Check all that apply):

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐Unemployed ☐ Student

Marital Status:

☐ Married ☐ Domestic Partner ☐ Single ☐ Divorced ☐ Other: _____

Emergency Contact: _____ Relationship: _____

Phone: _____

How did you hear about Us?

_____

Major Concern

What is your major concern?

_____

Other Concerns: _____

How long have you had this condition? _____

Have you had this or similar condition in the past? _____

What activities aggravate your condition? _____

What medications are you taking? (if any) _____

Non-prescription drugs? _____

Insurance Information (if applicable)

Insurance Company: _____ Policy Holder Name: _____

Birth Date (MM/DD/YY): _____ Relationship to Patient: _____

Insurace Company Address: _____ Telephone: _____

Policy Number / ID number : _____

Group Number: _____

Confidentiality: *Your Patient records and Information will be kept strictly confidential and will only be shared when necessary to provide your care, or under your written authorization, or when required by law.*

Signature _____ Date _____