WELCOME TO OUR OFFICE

Confidential Patient Information Name: ______________________________ Date: __________

Address: ______________________________ City: ____________________ State: ______ Zip: __________

Phone (Home): (____)__________________ (Work): (____)__________________ (Mobile): (____)__________________

Email: ______________________________ Referred By: ______________________________

Age: ______ Birth Date: ____________ Sex: M / F Marital Status: S / M / W / D

Occupation: ______________________________ Employer & Address: ______________________________

Spouse's Name: ____________________ Spouse's Work Phone: (____) ____________________Number of Children: ______

Emergency Contact: ______________________________ Contact Phone: (____) ____________________

Date of Last Physical Exam: ____________ With Whom: ____________________ Where: ____________________

Reported Findings: ____

Surgeries, Hospitalizations, Serious Illnesses (List Year in Brackets): ______________________________

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Fractures, Dislocations, Major Dental Work (List Year in Brackets): ______________________________

Conditions You Have Had:

_ Allergies	_ Diabetes	_ Neck Pain	_ Sinus Troubles
_ Alcoholism	_ Digestive Disorders	_ Neuritis	_ Stroke
_ Anemia	_ Dizziness	_ Nervousness	_ Tuberculosis
_ Arthritis / Joint Pain	_ Epilepsy	_ Numbness	_ Ulcer
_ Asthma	_ Fatigue	_ Parasites	_ Urinary Trouble
_ Backaches	_ Headaches	_ Poor Appetite	_ Venereal Disease
_ Breathing Problems	_ Heart Trouble	_ Poor Circulation	_ Weight Loss
_ Cancer	_ High Blood Pressure	_ Prostate Problems	_ Yeast / Candida
_ Depression	_ Hypoglycemia	_ Rheumatic Fever	_ ______________

Purpose of This Appointment: ____

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Other Doctors Seen For This Condition: ____

Have You Been Treated For Any Other Condition in The Past Year? Yes / No (If So, Describe): ______________________________

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Medications / Drugs You Are Taking (state reason in brackets following drug): ______________________________

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Remarks / Additional Information: ____

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PAYMENT IS EXPECTED AT TIME OF VISIT

Name of Person Responsible for Payment: ______________________________

Address & Phone (if different than yours): ______________________________

PATIENT AGREEMENT: I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that I am personally responsible for payment, both for services when rendered and for missed appointments if I fail to give twenty-four hour advance notice of cancellation.

Signature: ______________________________ Parent / Guardian Signature: ______________________________ Date: __________