

PATIENT CONFIDENTIAL INFORMATION

Name _____ Date _____
Address _____ City & Zip code _____
Home Phone _____ Work Phone _____
Age _____ Date of Birth _____
Sex Male [] Female [] Marital Status Single [] Married []
S.S.N _____ ID No _____

*Optional

Fax _____ E-Mail _____
Occupation _____ Employer _____
Employer's Address _____ Phone _____

Chief Complain _____
Complaint Result of _____
Auto Accident [] Injury [] Job Related [] Other []
Date of Accident/ Injury / Other _____
Have you taken any treatment for this condition? _____
If yes, When? _____

Do you have tendency to faint? Yes No Are you HIV positive? Yes No
Do you have pacemaker? Yes No (Women) Are you pregnant? Yes No
Do you bleed for long time? Yes No What kind of medication are you on now? _____

Cash [] Check [] Insurance [] Other []
Company Name _____ Policy Number _____
Insured Name _____
Insurance Address _____

CANCELATION AND NSF POLICY

1. If you need cancel your appointment, please inform us at least 24 hours prior to your appointment to avoid full service charge. A missed appointment will be charged at a full rate.
2. There is service charge of \$20.00 of every returned check from the bank.

I have read and filled above information and certify it to be true and correct to the best of my knowledge and belief. I authorize the release of any medical records/ other information necessary to claim with my insurance.

Date _____ Referred by _____

Patient Signature _____