DATE: _____ FACE SHEET # _____ COMPUTER ID # _____

PATIENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	SUFFIX	AGE	DATE OF BIRTH

STREET ADDRESS	APT.#	CITY	STATE	ZIP

DO YOU CURRENTLY RESIDE IN A NURSING FACILITY?	IF SO, NAME OF NURSING FACILITY	SEX	MARITAL STATUS
☐ YES ☐ NO		☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

HOME PHONE	CELL PHONE	EMAIL ADDRESS	NAME OF FAMILY PHYSICIAN

NEAREST RELATIVE (spouse, parent, etc.)	ADDRESS	RELATIONSHIP	PHONE

EMERGENCY CONTACT NAME	RELATIONSHIP	PHONE	REFERRED TO THE OFFICE BY

EMPLOYMENT INFORMATION (For patient, spouse, and/or both parents)

PERSON EMPLOYED	DATE OF BIRTH	JOB TITLE	WORK PHONE	CELL PHONE

EMPLOYER	ADDRESS

PERSON EMPLOYED	DATE OF BIRTH	JOB TITLE	WORK PHONE	CELL PHONE

EMPLOYER	ADDRESS

IS PATIENT A STUDENT?		NAME OF SCHOOL
☐ YES ☐ NO	☐ FULL-TIME ☐ PART-TIME	

INSURANCE INFORMATION

COMPANY NAME OF PRIMARY INSURANCE	GROUP #	INSURED	IDENTIFICATION NUMBER
COMPANY NAME OF SECONDARY INSURANCE	GROUP #	INSURED	IDENTIFICATION NUMBER
COMPANY NAME OF THIRD INSURANCE	GROUP #	INSURED	IDENTIFICATION NUMBER

ACCIDENT INFORMATION

TYPE OF ACCIDENT (FALL, AUTO, ETC.)	PLACE OF ACCIDENT (HOME, WORK, ETC.)	DATE OF ACCIDENT

IF ACCIDENT HAPPENED AT WORK, NAME OF EMPLOYER	WAS INJURY REPORT FILED

IS THIS A LEGAL CASE?	NAME OF ATTORNEY	ATTORNEY ADDRESS AND PHONE

MEDICAL INFORMATION

TODAY'S PROBLEM (example: LEG, ARM, etc. - also, RIGHT or LEFT)	
	☐ RIGHT side ☐ LEFT side
IF TREATED AT A HOSPITAL - WHERE?	WHEN?
IF TREATED BY ANOTHER DOCTOR - WHERE?	WHEN?
IF X-RAYS WERE TAKEN - WHERE?	WHEN?

MEDICAL HISTORY - Circle One					
High Blood Pressure	YES	NO	Heart Problems	YES	NO
Diabetes	YES	NO	Smoker	YES	NO
Kidney Disease	YES	NO	Other _____		

IF ON MEDICATION - PLEASE LIST	
DO YOU HAVE ALLERGIES? ☐ YES ☐ NO	IF YES, PLEASE LIST HERE

*** * PLEASE BE ADVISED * ***

THIS OFFICE DOES NOT WAIT FOR LEGAL CASES TO BE SETTLED FOR PAYMENT OF YOUR BILL - WE CONSIDER *YOU* RESPONSIBLE FOR YOUR BILL