

# PATIENT HISTORY

TODAY'S DATE \_\_\_\_\_

ACCOUNT # \_\_\_\_\_

DR # \_\_\_\_\_ BC # \_\_\_\_\_

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)				LIST ANY ALLERGIES			
PATIENT'S CURRENT ADDRESS			APT. #	CITY, STATE		ZIP CODE	TELEPHONE W/AREA CODE — —
PATIENT'S PERMANENT ADDRESS (if other than current)				CITY, STATE		ZIP CODE	TELEPHONE
SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER			OCCUPATION

PATIENT'S EMPLOYER			EMPLOYER'S ADDRESS			TELEPHONE
SPOUSE/NEAREST RELATIVE		RELATIONSHIP	ADDRESS/CITY/STATE/ZIP			TELEPHONE
<b>RESPONSIBLE PARTY - PERSON WHO CARRIES INSURANCE</b>			RELATIONSHIP	<b>SOCIAL SECURITY NUMBER</b>		<b>RESP. PARTY DOB</b>
RESPONSIBLE PARTY ADDRESS			CITY, STATE		ZIP CODE	TELEPHONE
RESPONSIBLE PARTY EMPLOYER			EMPLOYER'S ADDRESS			TELEPHONE
NAME OF RELATIVE NOT LIVING WITH YOU			ADDRESS			TELEPHONE

REFERRED BY:  PHYSICIAN (name) \_\_\_\_\_  FRIEND (name) \_\_\_\_\_  SCHOOL (name) \_\_\_\_\_

FAMILY PHYSICIAN (if other than referring doctor)		AREA OF COMPLAINT			
		INJURY? (Please Circle)			
		SPORTS	WORK	AUTO	SCHOOL
DATE OF INJURY	PREVIOUSLY TREATED HERE? <input type="checkbox"/> YES <input type="checkbox"/> NO	DOMINANT HAND?			
	BY WHOM?	<input type="checkbox"/> LEFT <input type="checkbox"/> RIGHT			

PRIMARY INSURANCE		TELEPHONE NUMBER		SECONDARY INSURANCE		TELEPHONE NUMBER			
ADDRESS				ADDRESS					
CITY, STATE			ZIP CODE		CITY, STATE			ZIP CODE	
POLICY #		ID #/GROUP #			POLICY #		ID #/GROUP #		
NAME OF POLICYHOLDER		RELATIONSHIP TO POLICYHOLDER			NAME OF POLICYHOLDER		RELATIONSHIP TO POLICYHOLDER		
SOCIAL SECURITY #		POLICYHOLDER'S EMPLOYER			SOCIAL SECURITY #		POLICYHOLDER'S EMPLOYER		