DATE: _____ FACE SHEET # _____ COMPUTER ID # _____

## PATIENT INFORMATION

| FIRST NAME | MIDDLE INITIAL | LAST NAME | NAME OF FAMILY PHYSICIAN |
|---|---|---|---|
| | | | |

| STREET ADDRESS | APT.# | CITY | STATE | ZIP |
|---|---|---|---|---|
| | | | | |

| HOME PHONE | CELL PHONE | AGE | DATE OF BIRTH | SEX | MARITAL STATUS | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|---|---|
| | | | | ☐ MALE ☐ FEMALE | ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED | |

| 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 | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| EMPLOYER | ADDRESS | PHONE |
|---|---|---|
| | | |

| PERSON EMPLOYED | DATE OF BIRTH | JOB TITLE | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

| EMPLOYER | ADDRESS | PHONE |
|---|---|---|
| | | |

| 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 |
|---|---|---|
| | | |

*** * 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**

## MEDICAL INFORMATION

| PROBLEM BEING TREATED FOR (EXAMPLE: NECK, BACK, LEG, ARM, ETC. - ALSO, WHICH SIDE) | | | |
|---|---|---|---|
| | | | |

| IF TREATED BY ANOTHER DOCTOR - WHERE? | WHEN? | IF TREATED AT A HOSPITAL - WHERE? | WHEN? |
|---|---|---|---|
| | | | |

| IF X-RAYS WERE TAKEN - WHERE? | WHEN? | DO YOU HAVE ALLERGIES? | IF YES, PLEASE LIST HERE |
|---|---|---|---|
| | | ☐ YES ☐ NO | |

| LIST CHRONIC ILLNESSES (ie: hypertension, cholesterol, etc.) | IF ON MEDICATION - PLEASE LIST | RIGHT-HANDED | LEFT-HANDED |
|---|---|---|---|
| | | ☐ YES | ☐ YES |