Patient Forms

Basic Information

Full Name

First _____ Middle _____ Last _____ Suffix _____

Sex [ ]Male [ ]Female [ ]Unknown

Primary Phone

Home _____

Mobile _____

Work _____

Date of Birth: _____/_____/_____

Email _____

Social Security Number _____

Address Line 1 _____

Address Line 2 _____

City _____State_____ Zip _____

Marital Status _____

Maiden Last _____

Driver's License State _____

Driver's License# _____

Demographics

Sexual Orientation _____
Gender Identity _____

Hispanic or Latino? [ ]Yes [ ]No [ ]Decline to Specify _____

Ethnicity Race _____

Language _____

Patient Forms

Emergency Contact

Relationship to Contact _____

First _____Middle _____ Last _____

Primary Phones

Home _____

Mobile _____

Work _____

Address Line 1 _____

Address Line 2 _____

City _____State_____ Zip _____

Financial Information

Responsible Party _____

Who will be financially responsible for you?
[ ]Myself
[ ]Someone else

If you chose "Someone Else ", please fill out the following:

Relationship to Contact _____

Relationship to Contact _____

First _____Middle _____ Last _____

Primary Phones

Home _____

Mobile _____

Work _____

Address Line 1 _____

Address Line 2 _____

City _____State_____ Zip _____

Phone

Home _____

Mobile _____

Work _____

Patient Forms

Method of Payment

What will be your method of payment?
[ ]Insurance
[ ]Self-Pay

If you chose " Insurance", please fill out the following :

PRIMARY INSURANCE POLICY

Insurance Company _____

Policy Number _____

Insurance Plan _____

Insurance Phone Number _____

Group Number _____

Address Line 1 _____

Address Line 2 _____

City _____State_____ Zip _____

Relationship to Primary Policy Holder

If you are not the primary policy holder, please fill out the following:

Your Name _____

Insurance Company _____

Policy Number _____

Insurance Plan _____

Insurance Phone Number _____

Group Number _____

Address Line 1 _____

Address Line 2 _____

City _____State_____ Zip _____

Sex [ ]Male [ ]Female [ ]Unknown

Date of Birth: _____/_____/_____

Policy Holder Address _____

Address Line 2 _____

City _____State_____ Zip _____

If you are unable to provide your insurance information , please provide a reason before continuing .

Patient Forms

SECONDARY INSURANCE POLICY

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____

Policy Number _____

Insurance Plan _____

Insurance Phone Number _____

Group Number _____

Address Line 1 _____

Address Line 2 _____

City _____State_____ Zip _____

Relationship to Secondary Policy Holder

If you are not the secondary policy holder, please fill out the following :

Your Name _____

Insurance Company _____

Policy Number _____

Insurance Plan _____

Insurance Phone Number _____

Group Number _____

Address Line 1 _____

Address Line 2 _____

City _____State_____ Zip _____

Sex [ ]Male [ ]Female [ ]Unknown

Date of Birth: _____/_____/_____

Policy Holder Address _____

Address Line 2 _____

City _____State_____ Zip _____

Patient Forms

Pharmacy

Please list your preferred pharmacies in order of preference

Pharmacy Name _____

Pharmacy Address_____

City _____State_____ Zip _____

How did you hear about us?

Patient Forms

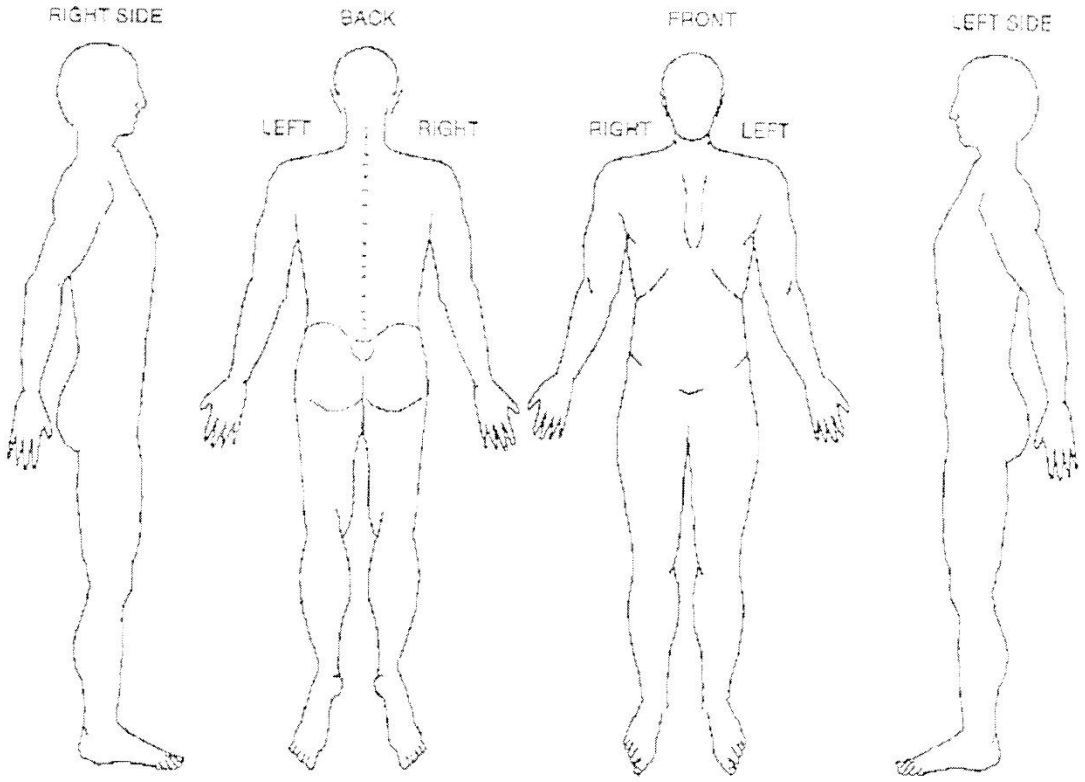
PAIN ASSESSMENT

Name: _____

Date of Birth: _____/_____/_____

Date: _____

PLEASE MARK OR SHADE IN THE AREAS OF YOUR BODY WHERE YOU FEEL PAIN ON THE DIAGRAMS BELOW.



Next to each area marked above please note the intensity of pain.

0- NO PAIN
1-2 MINIMAL
3-4 TOLERABLE BUT HINDERS ACTIVITIES
5-6 HIGH 50% OF ACTIVITIES IMPAIRED
6-7 EXTREME MOST ACTIVITIES IMPAIRED
9 UNBEARABLE