PATIENT INFORMATION

PATIENT'S PERSONAL INFORMATION

Date: _____

Name: _____ ☐ M ☐ F DOB: _____

Address:_____City:_____State:_____ _Zip:_____

Home Phone: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Social Security Number: _____ - _____ - _____

Occupation:_____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Pharmacy: _____

Spouse's Name:_____ Work Phone: (_____)_____

PATIENT'S / WORK RELATED INJURY

Is your condition a result of a work injury? ☐ YES ☐ NO Date of Injury: _____

Is your condition a result of an auto accident? ☐ YES ☐ NO

Worker's Compensation Insurance Company Name:_____

Address:_____City:_____State:_____Zip:_____

Adjuster:_____ Claim #:_____

Phone: (_____)_____ Fax: (_____)_____

Nurse Case Manager: _____

Phone: (_____)_____ Fax: (_____)_____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

Primary Insurance Company:_____

Address:_____City:_____State:_____Zip:_____

Name of Insured: _____DOB:_____ Relationship to Patient:_____

Insurance ID Number: _____ Group Number:_____

Secondary Insurance Company:_____

Address:_____City:_____State:_____Zip:_____

Name of Insured: _____DOB:_____ Relationship to Patient:_____

Insurance ID Number: _____ Group Number:_____

PATIENT'S REFERRAL INFORMATION

Primary Care Physician: _____ Referred By:_____

Assignment of Benefits ● Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Noah D. Weiss, M.D., and any assisting physicians, for services rendered. I understand that I am financially responsible for all changes whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:_____ **Date:**_____

Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

PATIENT INFORMATION

PATIENT INFORMATION

Date: _____

Name: _____ □ M □ F Age: _____ DOB: _____

Height: _____ Weight: _____ Dominant Hand: □ R □ L

Who Referred you to this practice? _____

Email Address: _____

HISTORY OF INJURY

Area of Problem or Injury/ Body Part:

Date of Injury: Onset: ☐ Gradual (came on slowly) or ☐ Sudden (happened all at once)

How Did Your Injury Occur?:

Chief Complaint and Symptoms (What bothers you?):

PATIENT INFORMATION

What makes it Worse?:

What makes it Better?:

What can you not do now that you could do before your injury?

Have you seen any other doctors about this condition? ☐ **YES** ☐ **NO**

If so, whom? Date:

_____ _____

_____ _____

_____ _____

Have you hand any of the following tests or studies already done? If so, when?:

☐ X-rays ☐ CT scans

☐ MRI ☐ Nerve Conduction Studies

☐ Blood tests ☐ Other tests

What type of treatment have you had so far?

☐ Brace or splint ☐ Physical therapy (Dates) _____

☐ Chiropractic ☐ Injections

☐ Hospitalized ☐ Surgery (What kind) _____

☐ Other _____

☐ Medications _____

PATIENT INFORMATION

HISTORY OF PREVIOUS INJURY

Have you injured this body part before? ☐ **YES** ☐ **NO** If Yes, when? _____

What were your symptoms prior to this injury?

PAST MEDICAL HISTORY

General Status of Health: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Have you ever had any of the following?

☐ Diabetes I or II	☐ Bleeding Problems	☐ Malignancies, Cancer	☐ Asthma
☐ Arthritis	☐ High blood pressure	☐ Neurological Problems	☐ Angina
☐ Thyroid disorder	☐ High Cholesterol	☐ Hormone Disorder	☐ Epilepsy
☐ Heart attack	☐ Frequent Heartburn	☐ Hereditary Problems	☐ Hiatal Hernia
☐ Kidney Disease	☐ Psychiatric Illness	☐ Irregular heartbeats	☐ Eating Disorder
☐ Emphysema	☐ Gout	☐ Reynaud's Disease	☐ Hepatitis, Liver Disease

☐ Other Illnesses or Injuries: _____

_____

Primary Care Physician: _____

PAST SURGICAL HISTORY

☐ **NONE**

Type of Surgery	Doctor	Hospital	Approximate Date

PATIENT INFORMATION

ALLERGIES

Are you allergic to any type of drug or medicine? ☐ **YES** ☐ **NO**

If yes, please list and include symptoms:

Are you allergic to Latex? ☐ **YES** ☐ **NO**

MEDICATIONS AND DIETARY SUPPLEMENTS

☐ **NONE**

Medication	Dosage/Frequency

PATIENT INFORMATION

FAMILY HISTORY

Do any of the following medical conditions run in your family?

☐ High Blood Pressure ☐ Cancer (what kind?) _____

☐ Diabetes ☐ Other: _____

☐ Unknown ☐ None

SOCIAL HISTORY

Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Do you have any children? If so, how many and what age? _____

Do you smoke cigarettes?:

☐ Yes: How many packs per day?:_____ For how many years:_____

☐ Former Smoker: When did you quit?:_____

☐ Never Smoked

Do you drink alcohol?:

☐ Yes: ☐ Social/Occasional Drinker ☐ Daily How many drinks per day?:_____

☐ No, I don't drink any alcohol

Other drugs: _____

Sports, Hobbies, Other jobs:

Occupation: Employer:

Current Work Status: Last Date Worked:

PATIENT INFORMATION

REVIEW OF SYSTEMS

Do you have any of the following?

☐ Headaches	☐ Shortness of Breath	☐ Recent unexplained weight loss
☐ Vision Problems	☐ Stomach Ache	☐ Morning Stiffness
☐ Ringing in Ears	☐ Burning Urination	☐ Joint to joint pain
☐ Hearing Loss	☐ Coughing up blood	☐ Numbness, tingling
☐ Sore Throat	☐ Blood in bowel movements	

Is there anything else regarding your health that we should know when treating you?

_____

_____

_____

The above is accurate to the best of my knowledge.

Signature: _____ **Date:** _____

PATIENT INFORMATION