

BILLING INFORMATION AND REGISTRATION FORM

Last Name _____ First Name _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone # _____ Date of Birth _____ Sex (M/F) _____

Your Cell Phone # _____

Name & Phone of Nearest Relative (not living with you) _____

Referred by _____ Social Security # _____

EMPLOYER INFORMATION

Company Name _____ Work Phone _____ Ext _____

Address _____ City _____ State _____ Zip _____

BILLING ADDRESS

Name of responsible party (if other than yourself) _____

Address _____ City _____ State _____ Zip _____

Relationship _____ Phone # _____

INSURANCE INFORMATION * please present insurance cards at check-ins

Insurance 1 _____ Co-pay Amount _____

Subscriber Name _____ Relationship _____

Certificate # _____ Group # _____

Insurance 2 _____ Co-pay Amount _____

Subscriber Name _____ Relationship _____

Certificate # _____ Group # _____

Date of birth of the subscriber (if different form self) _____

Is condition related to employment? _____ Auto accident? _____ Other accident? _____

.....>>>>.....

I authorize the release of any medical information necessary to process this claim.

Signature _____ Date _____

I authorize payment of medical benefits to my physician or supplier for services provided.

Signature _____ Date _____

Patient Health History Form

Name _____ DOB _____ Todays Date _____

SS # _____ Primary Care Physician _____

Past medical history – Please put a checkmark if you have had any of the following:

Asthma Kidney Disease High Cholesterol Alcoholism
 Emphysema Arthritis TB Thyroid Disease
 High Blood Pressure Aids Bleeding Disorder Stroke
 Congestive Heart Failure Cancer Depression Seizure Disorder
 Angina (Heart Attack) Diabetes Hepatitis / Liver Problems

Please describe any other medical conditions not listed above: _____

Medications - Please list all medications that you currently take

Name	Dose	Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any allergies to medications: _____

Systems review – Please check if you have any problems with any of the following:

Sensory/Skin (eyes, ears, skin) Neurological (balance, strength, fainting, blackouts)
 Respiratory (breathing problems) Gastrointestinal (swallowing, digestive, bowels)
 Cardiovascular (heart conditions) Endocrine (thyroid, diabetes)
 Genitourinary (urination, STD) Musculoskeletal (fractures, tendons, joints)
 Immunologic (allergies) Psychiatric (depression, behavior problems)
 Hematologic (lymphoma, myeloma, sickie cell)

Family History – Has amember of you family (Mother, Father, Sister, Brother_ ever had...

Hypertension Alcoholism Diabetes Anesthesia reaction
 Heart Attack Cancer Stroke Arthritis

Past Surgical History

Procedure _____ Date _____ Complications _____
Procedure _____ Date _____ Complications _____
Procedure _____ Date _____ Complications _____
Procedure _____ Date _____ Complications _____

Have you ever had general anesthesia? ___Yes ___No Adverse Reaction? ___Yes ___No

Social History

Smoke Currently? ___Yes ___No Packs per day for _____ years

Your Height _____ Your Weight _____

Quit smoking? _____ this year _____>1 year _____>5 years _____>10 years

Previously smoked: _____ packs per day for _____ years

Drink alcohol _____ daily _____ 1-2 drinks per week _____ 1-2 drink per month _____ drinks per year

Exercise _____ daily _____ 3 - 4 times/week 1 - 2 times a week _____ rarely

Occupation: _____

Marital Status _____ married _____ single _____ divorced _____ widowed

Children _____ No _____ Yes How many? _____

Reviewed by: _____ **MD** **Date:** _____