CASE HISTORY

Please fill out all sections

Name____**Date**___________________________________

Address____

City______________________________ **State**__________________ **Zip**___________________________

Best contact #:______________________Alternate contact #____________________**Birth date:** __________

Social Security #________________________ Age_________ Sex (M / F)

Occupation________________________ Employer________________________ Years Employed________

(Marital Status:M S W D DP)**Emergency Contact & #** ____

Email Address____ Fax___________________________

Spouse's Name_________________ Occupation___________________ Employer____________________

Employer's Address____

City_____________ State_____ Zip_______Work telephone________________________ Extension_______

Person responsible for this account____

What is your major complaint? ____

Current physicians treating for condition: ____

MAY OUR OFFICE HAVE YOUR PERMISSION TO FORWARD EXAM FINDINGS AND TREATMENT PLAN TO YOUR CURRENT PHYSICIAN? YES NO

HIPAA Acknowledgement

(Please read provided copy)

I have read and understand my rights regarding the HIPAA Privacy Act. I authorize you to use or disclose my health information in the manner describe. I understand I can request to have a copy of this document upon request at any time.

Patient's Signature____ **Date:** __________

(All of the information I have provided is correct to the best of my knowledge.)

Authorized Office Representative______________________________

Personal Injury Patients Only

Is your condition due to an accident? ___________

ACCIDENT INFORMATION:

Date________ Time_______ Injury reported to employer? _________ Name of supervisor________________

Description of accident____

____

Name and address of attorney____

We will need the following: Health INS, YOUR auto INS, 3rd Party auto INS, and police report.