

Welcome

ABOUT YOU				
Today's Date: File Number:				
Patient Name:				
LAST FIRST	MI MI			
What you prefer to be called:	Gender: ☐ Male ☐ Female			
Birthdate: Age: SSN: SSN:				
Mailing Address:				
City:	State: Zip:			
Home Phone #: Work Phone #:	ext.			
Mobile Phone #: Other Phone #:				
Email Address:				
Referred By:				
Employer:	How Long:			
Employer's Address:				
City:	State: Zip:			
Occupation:				
Status: Minor Single Married Divorced Separa	ated Widowed			
Spouse's Name:				
Do you have children: Yes No How many?				
INSURANCE INFORMATION				
Company Name:				
Address:				
City: State: Zip:				
Phone #: Insured's ID #:				
Group # (Plan, Local or Policy #):				
Insured's Name:				
Relation: Date of Birth:				
Insured's Employer: PLEASE INFORM DESK OF ADDITIONAL INSURANCE SOURCES. REASON FOR VISIT				
	Auto 🗆 Trauma 🗀 Chronic			
Explain what happened:				

When did the condition begin:					
Is this condition getting worse? Yes No Constant Comes and goes					
Is this condition interfering with your Work Sleep Daily routine ?					
If so, please explain:					
Have you been treated by a Medical Physician for this condition? Yes No					
If so, where?					
IN EVENT OF EMERGENCY					
Who should we contact?					
Home Phone #: ext					
Who is your Medical Doctor?					
Phone #:					
HEALTH HISTORY					
Are you taking any of the following medications?					
ts					
Yes No Heart Surgery / Pacemaker Yes No Congenital Heart Defect					

Please list anything that you may be allergic to:

List previous surgeries/treatments with dates:
List previous surgeries/ treatments with dates.
List any past serious accidents with dates:
Family Health History:
Do you: Take Supplements or Vitamins? Yes No Exercise? Yes No
Are you one a special diet? Yes No Since:
Do you smoke? Yes No How Much? packs/day How Long? years
Are you wearing: Heel Lifts Sole lifts Inner soles Arch supports
What is the age of your mattress?years Is it comfortable?YesNo
For women: Are you taking Birth Control? Yes No
Are you Pregnant? Yes No How Long? months Nursing? Yes No
ACCOUNT INFORMATION
Person ultimately responsible for account
Name:
Relation:
Billing Address:
City: State: Zip:
SSN: D.L.#:
Work Phone #:
Payment method: CASH Check Credit Card
Enter card # (If accepted) Initials:
I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
 We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in lull for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
Signature Date

Adult Patient	Parent 🗌	Guardian 🗌	Spouse