

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

confidential health information

1 PATIENT CONTACT		clinic id	date
last name		first name	m.i.
preferred to be called			
street			
city	state	zip	
home phone		mobile phone	
work phone		e-mail	

2 PATIENT PERSONAL			
age	date of birth	social security #	sex <input type="checkbox"/> male <input type="checkbox"/> female
status <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> partnered <input type="checkbox"/> widowed <input type="checkbox"/> separated <input type="checkbox"/> divorced			

3 EMERGENCY CONTACT	
name	home phone
relationship	work phone

4 SPOUSE OR GUARDIAN			
last name		first name	m.i.
employer name			
work phone	date of birth	social security #	

5 PATIENT EMPLOYMENT		
employer name	occupation	
street		
city	state	zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services
- My case may not be accepted for treatment at this clinic
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost

patient or guardian signature

date