WELCOME TO FLORENCE SPINE & NERVE

PATIENT INFORMATION

Date _____

Social Security # _____

Patient Name _____

Address _____

City _____ State _____

Zip _____ E-mail _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for ___ years

Occupation _____

Patient Employer/School _____

Employer/School Phone _____

Spouse's Name _____

SS# _____

Birthday _____

Spouse's Employer _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance Co. _____

Is patient covered by additional insurance? yes no

Secondary Ins. Co. _____

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Florence Spine & Nerve

Insurance Company

all insurance benefits, if any, otherwise payable to me for services rendered. I understand that i am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-name insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, or Guardian

_____

Printed Name

_____ _____

Date Relationship to patient

PHONE NUMBERS

Home Phone _____

Cell Phone _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____ Phone #_____

ACCIDENT INFORMATION

Is condition due to and accident? yes no

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?
Auto Insurance Employer Worker Comp. Other

Attorney Name _____

PATIENT CONDITION

Reason for Visit _____

When did symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

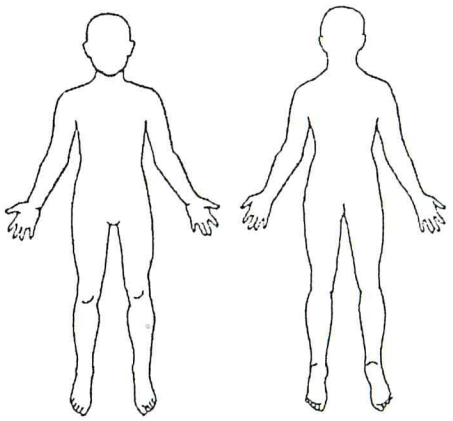
Mark and X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____



HEALTH HISTORY

What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic None Other _____

Date of Last: Physical Exam _____ Spinal X-ray _____ Blood Test _____

Spinal Exam _____ Chest X-ray _____ Urine Test _____

Dental x-ray _____ MRI, CT-scan, Bone scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Diabetes	Yes	No	Liver Disease	Yes	No	Rheumatic Fever	Yes	No
Alcoholism	Yes	No	Emphysema	Yes	No	Measles	Yes	No	Scarlet Fever	Yes	No
Allergy Shots	Yes	No	Epilepsy	Yes	No	Miscarriage	Yes	No	Sexually Transmitted Disease	Yes	No
Anemia	Yes	No	Fractures	Yes	No	Migraine Headaches	Yes	No	Stroke	Yes	No
Anorexia	Yes	No	Glaucoma	Yes	No	Mononucleosis	Yes	No	Suicide Attempt	Yes	No
Appendicitis	Yes	No	Goiter	Yes	No	Multiple Sclerosis	Yes	No	Thyroid Problems	Yes	No
Arthritis	Yes	No	Gonorrhea	Yes	No	Mumps	Yes	No	Tonsillitis	Yes	No
Asthma	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Bleeding Disorders	Yes	No	Heart Disease	Yes	No	Pacemaker	Yes	No	Tumors, Growths	Yes	No
Breast Lumps	Yes	No	Hepatitis	Yes	No	Parkinson's Disease	Yes	No	Typhoid Fever	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Pinched Nerve	Yes	No	Ulcers	Yes	No
Bulimia	Yes	No	Herniated Disc	Yes	No	Pneumonia	Yes	No	Vaginal Infections	Yes	No
Cancer	Yes	No	Herpes	Yes	No	Polio	Yes	No	Whooping Cough	Yes	No
Cataracts	Yes	No	High Blood Pressure	Yes	No	Prostate Problem	Yes	No	Other _____		
Chemical Dependency	Yes	No	High Cholesterol	Yes	No	Prosthesis	Yes	No	_____		
Chicken Pox	Yes	No	Kidney Disease	Yes	No	Psychiatric Care	Yes	No	_____		
						Rheumatoid Arthritis	Yes	No			

EXERCISE

None

Moderate

Daily

Heavy

WORK ACTIVITY

Sitting

Standing

Light Labor

Heavy Labor

HABITS

Smoking Packs/Day _____

Alcohol Drinks/Week _____

Coffee/Caffeine Drinks Cups/Day _____

High Stress Level Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

_____

_____

_____

_____

ALLERGIES

_____

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

_____