

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