PRO HEALTH & REHAB CLINICS

1.PATIENT INFORMATION

First Name: MI.: Last Name:

Address: City:

State: Zip.: Email:

Sex:M[ ] F[ ] Age: Birthdate: / /

If under 18 years old Gaurdian's Name:

Consent to treat a minor Signature:

Married[ ] Single[ ] Widowed[ ] Separated[ ] Divorced[ ]

SSN: - - Occupation:

Work Name & Address:

Spouse's Name: Spouse's Birthdate: / /

Spouse's Occupation:

Children's names and ages:

2.PHONE NUMBERS:

Home:

Work:

Cell:

Best time and place to reach you:

3.EMERGENCY CONTACT:

Name:

Relation:

Phone#:

4.INSURANCE INFO:

Company Name:

Name:

Policy#:

Grp #

PPO[ ] HMO[ ] Other[ ]

5.PATIENT CONDITION:

Chief Complaint:

When did your condition begin? Has this condition occurred before?

Is your condition getting worse? Yes[ ] No[ ] Unknown[ ]

Mark an x on the diagram indicating the area of discomfort.

Rate the severity of you pain (least pain) 1 2 3 4 5 6 7 8 9 10 (severe pain)

Type of pain: [ ]Sharp [ ]Dull [ ]Throbbing [ ]Numbness [ ]Aching [ ]Shooting

[ ] Burning [ ]Tingling [ ]Cramps [ ]Stiffness [ ]Swelling [ ]Other

How often do you experience this condition?

Have you seen any other Doctors for this condition? [ ]Yes [ ]No

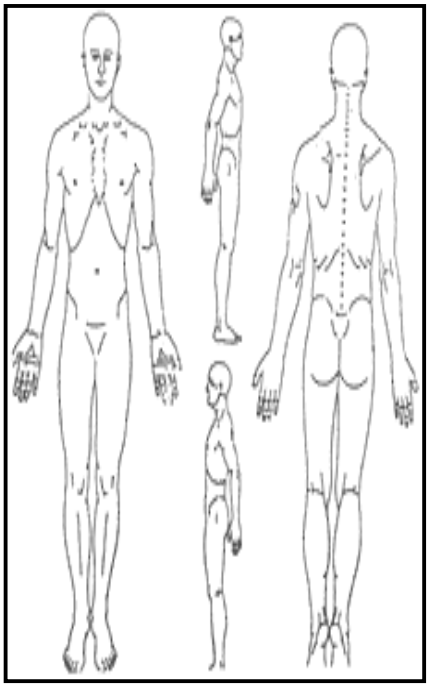
Who? Type of Treatment?

Is Condition [ ]Job Related [ ]Auto Accident [ ]Home Injury [ ]Fall [ ]Unknown

Date of Accident: Time of Accident:

Do you suffer from any condition other than the one listed above? [ ]Yes [ ]No

Please List:



Most patients that come into our office have one of two objectives in mind concerning their health care.Some seek symptomatic relief of pain(Relief Care) others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). The doctor will also recommend you a treatment program.

[ ] Corrective Care [ ] Relief Care [ ] Check if you want the Doctor to select type of care appropriate.

6.Assignment and Release:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that fees for services at this office are due and payable at the time of service and I authorize payment from any benefits carrier be made directly to Pro Health & Rehab with the understanding that all moneys will be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered will be immediately due and payable.

Patient's signature Date: