

**PATIENT INFORMATION**

First Name/Nombre:		Middle Initial	Last /Apellido:		Patient Account Number:	
Street Address/Direccion:			City/Ciudad:		State/Estado:	Zip/Codigo Postal:
Home Phone/# Casa:		Work Phone/Trabajo:		Cell Phone/# Celular:		
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Other		Date of Birth/Fecha de Nacimiento:		Age/Edad:	
Social Security Number/Seguro Social:		Referred by: (Doctor)/Referido Medico:		(Attorney)/Abogado:		Spouse Name/Espso/a:
IN CASE OF EMERGENCY - Contact:				Relationship:		
Home Phone:				Work Phone:		

**HEALTH INSURANCE INFORMATION**

Primary Insurance Company Name:			Telephone #:			
Insurance Address:		City:		State:	Zip:	
Policy Holder Name:			Identification #:			
Policy Holder Birth Date:		Group#:		Additional Info:		

**AUTOMOBILE ACCIDENT INFORMATION**

Date of Accident/Fecha de Accidente:		Med Pay? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how much? \$	
Insurance Company:		Address:		City/State:	
Adjuster Claim Rep:		Claim #		Phone #:	

**WORKERS' COMPENSATION INFORMATION**

Date of Accident:		Employed By:		Phone #:	
Insurance Company:		Address:		City/State:	
Adjuster		Claim #		Phone #:	
Claim Rep:					

**OTHER ACCIDENT / INCIDENT INFORMATION**

Other Accident/Incident Type (Describe Briefly):					
Insurance Company:		Address:		City/State:	
Adjuster:		Claim #		Phone #:	

**ATTORNEY INFORMATION**

Firm Name/Nombre de Firma:		Attorney Name/Abogado:		Phone #:	
Address:		City/State:		Zip:	

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment of surgical and/or medical benefits to be paid directly to the physician, if any, otherwise payable to me for his/her services as described realizing that I am responsible to pay non-covered services. I further authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.

Signature/Firma \_\_\_\_\_ Date/Fecha \_\_\_\_\_

Office Use Only (D/A) \_\_\_\_\_ (DX) \_\_\_\_\_

Date \_\_\_\_\_

▶ **PATIENT MEDICAL INFORMATION**

Patient Name \_\_\_\_\_ Patient Account Number \_\_\_\_\_

List all medications that you were taking before the accident.

\_\_\_\_\_

Are you allergic to any medications?  Yes  No

If yes, which medication(s)? \_\_\_\_\_

Date of Last Medical Exam: \_\_\_\_\_ with whom? \_\_\_\_\_

▶ **LIST OF MAJOR SURGERIES**

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

Have you had any major falls or accidents (automobile) in the past 3 years? Please describe below:

\_\_\_\_\_

▶ **SOCIAL AND OCCUPATIONAL HISTORY**

Employed by: \_\_\_\_\_  Unemployed  Housewife  Student

Type of work: \_\_\_\_\_

# of children and ages: \_\_\_\_\_

(1.) Do you smoke cigarettes/tobacco?  Yes  No

(2.) Do you use any illegal substances?  Yes  No

(3.) Do you consume alcohol?  Yes  No  Occasional

(4.) Are you HIV+/AIDS?  Yes  No

▶ **FEMALES ONLY**

Date of last menstrual cycle \_\_\_\_\_

Is there a possibility you may be pregnant?  Yes  No

If yes, due date \_\_\_\_\_

Currently taking birth control pills?  Yes  No

Currently taking hormone replacement?  Yes  No

▶ **PREVIOUS ILLNESSES**

Please advise which of the following conditions you have ever had.

ASTHMA:	SEIZURES:	NERVOUS CONDITIONS:
ARTHRITIS/BACK PAIN:	HEART PROBLEMS:	MENTAL ILLNESSES:
DEPRESSION:	DIABETES:	CANCER:
HIGH BLOOD PRESSURE:	STROKE:	HEADACHES:

▶ **FAMILY HISTORY**

Has your mother or father had any of these above conditions?

Mother: \_\_\_\_\_

Father: \_\_\_\_\_