

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Patient File #: _____

Today's Date: ____ / ____ / ____

WELCOME: The doctor and staff welcome you and want you to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to our care, we will refer you to the appropriate healthcare provider. If you are a candidate for care in this office, then a treatment plan will be recommended to fit your individual needs.

INSTRUCTIONS: Please complete the following information in its entirety. The information submitted on this form is strictly confidential. If you have difficulty understanding any portion of this for, please ask for assistance. If the question does not pertain to you, simply write in N/A for non-applicable.

PERSONAL INFORMATION:

Name: (First) _____ (Middle) _____ (Last) _____ Jr., II, III, IV
Address: _____ City: _____ State: _____ Zip: _____
Birth Date: ____ / ____ / ____ Age: ____ Marital Status (Circle): Divorced Married Single Separated Widowed
Gender (Circle): Male / Female Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____
Social Security #: _____ - _____ - _____ Email Address: _____ @ _____
Spouses Name: _____ Names & Ages of Children: _____
Is your spouse a patient in our office? Yes No

Employer / Employment Status Employed Unemployed Full Time / Part Time Student Other

Business Name: _____ Occupation/Job Title: _____

Business Address: _____

Business Phone: (____) _____ - _____ Type of Work: _____

Is it ok to contact you at work? Yes No

Emergency Contact Information

Name: (First) _____ (Middle) _____ (Last) _____ Jr., II, III, IV

Address: _____ City: _____ State: _____ Zip: _____

Relationship: _____ Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

PAYMENT/INSURANCE INFORMATION:

Is the condition(s) that brought you here today due to an automobile accident or on the job injury?

Yes No

Who besides yourself is responsible for your bill? Self-Pay Health Insurance

Medicare Medicaid Worker's Comp

Auto Insurance Other (Be Specific): _____

Personal Health Insurance Carrier: _____ Health ID Card #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: ____ / ____ / ____ Insured Person's Social Security #: _____ - _____ - _____

Auto or Workers' Comp Insurance Carrier & Claim #: _____

PRIMARY COMPLAINT:

When did it start? _____
Describe the condition: _____
What do you think caused the problem? _____
Rate the pain from 1-10: At it's worst _____ At the present time _____ At least severe _____
Does the pain travel? Yes No If yes, from where to where? _____
Is condition getting worse? Yes No
List the activities that this condition prevents you from doing? _____
List past treatment for this condition and if they helped _____

SECOND COMPLAINT:

When did it start? _____
Describe the condition: _____
What do you think caused the problem? _____
Rate the pain from 1-10: At it's worst _____ At the present time _____ At least severe _____
Does the pain travel? Yes No If yes, from where to where? _____
Is condition getting worse? Yes No
List the activities that this condition prevents you from doing? _____
List past treatment for this condition and if they helped _____

THIRD COMPLAINT:

When did it start? _____
Describe the condition: _____
What do you think caused the problem? _____
Rate the pain from 1-10: At it's worst _____ At the present time _____ At least severe _____
Does the pain travel? Yes No If yes, from where to where? _____
Is condition getting worse? Yes No
List the activities that this condition prevents you from doing? _____
List past treatment for this condition and if they helped _____

LIST MEDICATIONS, VITAMINS, SUPPLEMENTS:

LIST PAST TRAUMA, ACCIDENTS, INJURIES, HOSPITALIZATIONS, SURGERIES:

LIST FAMILY HISTORY, SOCIAL HISTORY, EXERCISE LEVEL, SMOKING, STRESS LEVEL:

Is there any other information that you feel would be relevant to your current condition(s) that was not covered? Please explain in the following section any information that you feel would be helpful to the doctor.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I authorize the release of any medical information necessary to process my insurance claims.

AUTHORIZATION OF ASSIGNMENT:

I authorize payment of medical benefits to _____ for services rendered to me.

REIMBURSEMENT POLICY:

We often do not know exactly what your insurance company will pay us until we receive payment. Either way, we usually accept their payment after any deductible, co-payment and co-insurance is handled. Please understand that your insurance is an agreement between you and your insurance company and all services rendered to you are ultimately your responsibility.

ACCEPTANCE AS A PATIENT:

I understand and agree that this office has the right to refuse to accept me as a patient at any time before treatment begins, or terminate my care as a patient if in the course of treatment if I am not following the treatment plan for my condition, or be referred out to another health provider as the doctor deems medically necessary. I understand that the taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

PATIENT PRINTED NAME

PATIENT SIGNATURE

DATE