INTRODUCTION PATIENT CASE HISTORY

Today's Date: _____

PATIENT INFORMATION

Name: (First MI Last) _____ **Preferred Name:** _____

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

Cell: _____ **Mobile Carrier:** _____ **Home:** _____ **Work:** _____

Email: _____ **Gender:** M / F **Marital Status:** _____

Social Security #: _____ **Date of Birth:** _____

Employer: _____ **Title:** _____

Ethnicity: Hispanic or Latina / Not Hispanic or Latino / Decline **Preferred Language:** English / Decline / Other: _____

Race: Asian / African American / American Indian or Alaskan Native / Other / Native Hawaii or Pacific Islander / White / Decline

*__How Did You Hear About Our Office?__ _____ Family / Friend / Co-Worker / Doctor / Other Source

EMERGENCY CONTACT INFORMATION

Name: (First MI last) _____ **Primary Care Physician:** _____

Home: _____ **Mobile:** _____ **Doctor's Phone:** _____

Relationship: Child / Parent / Spouse / Other: _____

FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (cash) ☐ Personal Injury/Auto ☐ Other

PRIMARY INSURANCE

Insurance Name: _____

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name_____ **Gender:** M / F

Address: _____

City: _____**State:** _____**Zip:** _____

Phone: _____ **Date of Birth:** _____

SECONDARY INSURANCE

Insurance Name: _____ **Gender:** M / F

Relation to Insured: Self / Spouse / Parent / Child / Other

Other than Self:
Insured's Name_____ **Gender:** M / F

Address: _____

City: _____**State:** _____**Zip:** _____

Phone: _____ **Date of Birth:** _____

RESPONSIBLE PARTY

Who is responsible for payment? Self / Other – (Relationship) _____

Address (if not self) _____ **City:** _____ **State:** _____ **Zip:** _____

Preferred method of payment: Cash / Check / Credit or Debit Card / Auto Pay Monthly with Debit or Credit Card

X **I guarantee any amount not covered by my insurance. Signature:** _____ **Date**: _____