

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

BIRTHDATE: _____

SSN#: _____

SEX: M F AGE: _____ MARITAL STATUS: _____

EMPLOYER/SCHOOL: _____

TITLE: _____

EMPLOYER/SCHOOL ADDRESS: _____

CHILDREN AGES: _____, _____, _____, _____, _____, _____

HOME PHONE: (_____) _____ - _____

CELL PHONE: (_____) _____ - _____

WORK PHONE (_____) _____ - _____

E-MAIL: _____

WHOM MAY WE THANK FOR REFERRING YOU:

Signature of patient

INSURANCE INFORMATION

WHO IS RESPONSIBLE FOR THIS ACCOUNT: _____

RELATIONSHIP TO PATIENT: _____

PRIMARY INSURANCE COMPANY: _____

GROUP# _____ POLICY# _____

MEMBER'S SSN# _____

MEMBER'S BIRTHDATE _____

IS THERE ADDITIONAL INSURANCE ____YES ____NO

ADDITIONAL INSURANCE CO: _____

MEMBER NAME: _____

MEMBER'S SSN# _____

MEMBER'S BIRTHDATE _____

GROUP# _____ POLICY# _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Clyde Porter, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Porter may use my health care information and may disclose such information to the above named insurance companies and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN DATE

PRINT NAME OF PATIENT, PARENT, OR GUARDIAN DATE

RELATIONSHIP TO PATIENT _____

SPOUSE INFORMATION

SPOUSE NAME: _____

BIRTHDATE: _____ SSN: _____

HOME PHONE: _____

WK PHONE _____

CELL PHONE _____

SPOUSE EMPLOYER _____

IN CASE OF EMERGENCY CONTACT: _____

HOME PHONE _____ WORK: _____

RELATIONSHIP: _____

IS CONDITION DUE TO ACCIDENT? YES NO

DATE: _____

AUTO WORK HOME

HAVE YOU MADE A REPORT OF YOUR ACCIDENT?

WORK COMP EMPLOYER AUTO INS

HEALTH HISTORY

What treatment have you already received for you condition?

Medication Surgery Physical Therapy Chiropractic None

Other _____

Name and address of other doctor(s) who have treated you for your condition:

Date of last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____ Dental X-Ray _____
MRI, CT-Scan, Bone Scan _____

Mark if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Measles	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Allergy Shots	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Stroke
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Fractures	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Suicide Attempt
<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Goiter	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Gout	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tumors, Growths
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Typhoid Fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pinched Nerve	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Bulimia	<input type="checkbox"/> Hernia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Vaginal Infections
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Polio	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate Problem	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Psychiatric Care
<input type="checkbox"/> Chemical Dependency		<input type="checkbox"/> Other _____	

Exercise

None
 Moderate
 Daily
 Heavy

Work Activity

Sitting
 Standing
 Light Labor
 Heavy Labor

Habits

Smoking packs/day _____
 Alcohol drinks/week _____
 Coffee/Caffeine Drinks cups/day _____
 High Stress Level reason _____

Are you pregnant?

YES NO

Due Date _____

Injuries/Surgeries you have had:

Falls _____ Dates: _____

Head Injuries _____ Dates: _____

Broken Bones _____ Dates: _____

Dislocations _____ Dates: _____

Surgeries _____ Dates: _____

Medications

Allergies

Vitamins/Herbs/Minerals

