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INFORMATION REQUIRED FOR CASE HISTORY FILE

DATE \_\_\_\_\_  
PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
STREET \_\_\_\_\_ PHONE \_\_\_\_\_ SEX \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  
CITY \_\_\_\_\_ ZIP \_\_\_\_\_ MARITAL STATUS M S W D  
OCCUPATION \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ Referred By \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
DRIVERS LICENSE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_-\_\_\_\_-\_\_\_\_\_  
IN CASE OF EMERGENCY PLEASE NOTIFY \_\_\_\_\_ PHONE \_\_\_\_\_

**BILLING INFORMATION**

NAME OF INSURANCE SUBSCRIBER \_\_\_\_\_  
(PLEASE CIRCLE ONE) SELF, MOTHER, FATHER, SPOUSE, EMPLOYER  
ADDRESS (if different from patient) \_\_\_\_\_  
PHONE \_\_\_\_\_ SUBSCRIBER'S DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_-\_\_\_\_-\_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**INSURANCE INFORMATION**

DO YOU HAVE PRIVATE OR GROUP INSURANCE YES \_\_\_\_\_ NO \_\_\_\_\_  
NAME OF YOUR INSURANCE COMPANY: PRIMARY \_\_\_\_\_  
(PLEASE CIRCLE ONE) SELF, MOTHER, FATHER, SPOUSE, EMPLOYER  
SUBSCRIBER/ID# \_\_\_\_\_ GROUP# \_\_\_\_\_  
SECONDARY \_\_\_\_\_  
(PLEASE CIRCLE ONE) SELF, MOTHER, FATHER, SPOUSE, EMPLOYER  
SUBSCRIBER/ID# \_\_\_\_\_ Group# \_\_\_\_\_

PLEASE PRESENT YOUR INSURANCE CARD AND PHOTO ID AT THE FRONT DESK.

**GENERAL HISTORY**

WERE YOU INJURED ON THE JOB? YES \_\_\_ No \_\_\_ AUTO ACCIDENT YES \_\_\_ NO \_\_\_ / PERSONAL INJURY YES \_\_\_ NO \_\_\_  
TYPE OF PROBLEM, OR PART INJURED \_\_\_\_\_ RIGHT OR LEFT  
DATE OF ONSET OF COMPLAINT, OR DATE OF INJURY \_\_\_\_\_ DATE LAST WORK \_\_\_\_\_  
IF INJURY OF ACCIDENT, WHERE DID IT OCCUR? \_\_\_\_\_  
HAS ANY OTHER M.D. TREATED YOU FOR THIS CONDITION YES \_\_\_\_\_ NO \_\_\_\_\_  
NAME OF PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_  
ARE YOU ALLERGIC TO ANY MEDICATION? PLEASE LIST \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE (consent for treatment and for acceptance of financial responsibility)  
(Parent or legal guardian must sign if the patient is a minor.)

**ASSIGNMENT OF BENEFITS**

I hereby authorize the above doctors to furnish to my insurance company all information which my insurance company may request concerning my illness or injury. I hereby assign the above doctors all payments to which I am entitled for Medical and/or surgical expenses. I understand I am financially responsible to the above doctors for charges not covered by this assignment. A Photostat of this assignment is as valid as the original.

SIGNED \_\_\_\_\_  
(SIGNATURE OF POLICY HOLDER)