

HISTORY FORM

PLEASE PRINT CLEARLY

DATE _____

PATIENT'S NAME _____ DOB _____ AGE _____ SEX _____

ADDRESS _____ S _____ M _____ D _____ W _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY/STATE/ZIP _____

SPOUSE'S NAME _____ DOB _____ SS# _____

EMPLOYER _____ PHONE NUMBER _____

ADDRESS _____ CITY/STATE/ZIP _____

FAMILY PHYSICIAN _____ REFERRING DOCTOR _____

NEAREST (LOCAL) RELATIVE OR FRIEND NOT LIVING WITH YOU:

NAME _____ PHONE _____

ADDRESS _____ CITY/STATE/ZIP _____

IF PATIENT IS A CHILD, PLEASE INDICATE IF PARENT(S) ARE:

MARRIED _____ DIVORCED _____ SEPARATED _____ DECEASED _____

IT IS THE POLICY OF THIS OFFICE THAT THE PARENT ACCOMPANYING THE CHILD FOR TREATMENT WILL BE HELD RESPONSIBLE FOR ALL BILLS! WE CANNOT BILL THE OTHER PARENT.

FATHER'S NAME _____ DOB _____ PHONE _____

HOME ADDRESS _____ CELL PHONE _____

CITY/STATE/ZIP _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE _____

MOTHER'S NAME _____ DOB _____ PHONE # _____

HOME ADDRESS _____ CELL PHONE _____

CITY/STATE/ZIP _____

EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ WORK PHONE _____

EMAIL ADDRESS _____