CONFIDENTIAL PATIENT INFORMATION

※ Should you have any questions filling out this form, please feel free to ask the receptionist.

1. Name：_____ Sex：M・F 2. Address：_____

3. Phone（House）：_____ City：_____ State：_____

（Cell）：_____ ZIP：_____

4. D.O.B.：_____/_____/_____ Age：_____ 5. Martial Status：S・M・D・W

(MONTH) (DATE) (YEAR)

6. Number of Children：_____ 7. Email: _____

8. Occupation：_____ 9. Spouse's Name：_____

Employer：_____ Occupation：_____

Address：_____ 10. **Emergency Contact Info**

Phone：_____ Name：_____

e-mail：_____ Phone：_____

11. Driver's License：_____ Relationship：_____

12. Where did you hear about us？

Friend：_____ Magazine：_____ Other：_____

13. Do you have insurance？ ☐NO ☐YES

Insurance Company：_____ ID＃：_____

14. Last visit to a Doctor's office：_____/_____/_____

(MONTH) (DATE) (YEAR)

15. Have you had any surgery before？ ☐NO ☐YES If so, when？_____

What kind of surgery was performed？_____

16. Have you ever been severely injured？ ☐NO ☐YES If so, when？_____

What ？_____

17. Please check any of the following that applies：

❑ Dizziness	❑ Pain in joints	❑ Gastroenteritis	❑ Arthritis	❑ Poor Blood Circulation
❑ Back pain	❑ Head ache	❑ Nervousness	❑ Cancer	
❑ Heart Disease	❑ Numbness	❑ Rhinitis / Nasal Inflammation	❑ Shortness of Breath	❑ Shiver
❑ Diabetes	❑ Asthma			❑ Strain
❑ Tuberculosis	❑ Neuralgia	❑ Anemia		

18. Reason for today's visit：_____

19. Have you visited any other Doctor(s) with the same symptom？ ☐NO ☐YES

20. Within the past year, have you had any treatment(s) performed by a Doctor？ ☐NO ☐YES

If so, what kind of treatment(s)？_____

Currently, are you under any medication ？_____

◎I hereby approve the Doctor to bill directly to my Insurance Company, and to receive payment directly from my Insurance Company. I understand any amount not covered by my Insurance Company will be my responsibility.

Name (please print)：_____

Signature：_____ SS#：_____ Date：_____

If under the age of 18, Signature of the Guardian：_____ Date：_____