

PATIENT INFORMATION	MEDICAL INFORMATION
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Name: Mr/Mrs/Ms/Dr (circle)
 FIRST: _____ LAST: _____
 Preferred name: _____ Sex: M F
 D.O.B. (d/m/y) ____/____/_____
 Address: _____ Apt/Suite: _____
 City, Province: _____ Postal Code: _____
 Occupation: _____ Employer/School: _____
 Phone number (check box of preferred number):
 H (____) _____ W (____) _____
 Preferred time to call: Morning Afternoon Evening
 E-mail: _____
 Account responsibility: _____ Relationship: _____
 Whom may we thank for referring you? _____

Please fill in completely, check answer where applicable.
 Physician: _____
 Phone: _____
 Date of last medical examination: _____
 Are you under the regular care of a physician? Yes No
 If yes, please explain:

INSURANCE INFORMATION

Primary Insurance
 Insurance Company: _____ Policy #: _____
 Policy Holder: _____ D.O.B. (d/m/y): _____
 Relationship to Patient: _____
 Plan/Group #: _____ I.D. #: _____

Co-insurance
 Insurance Company: _____ Policy #: _____
 Policy Holder: _____ D.O.B. (d/m/y): _____
 Relationship to Patient: _____
 Plan/Group #: _____ I.D. #: _____

Have you ever had an injury, surgery, or radiation therapy to your head, face, jaws or neck?
 Yes No
 If yes, please explain:

 Please list all allergies: n/a

 Please list all medications and dosages you are currently taking or have taken in the past year: n/a
 (additional space on next page):

Do you currently, or have you ever had (please check all that apply):

- | | | |
|--|---|---|
| <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Swelling of Ankles |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Abnormal blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Tendency to Bruise or Bleed Easily |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Asthma/Bronchitis | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sensory Dysfunction [sight/hearing/speech/smell] |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Acid | <input type="checkbox"/> Reflux | <input type="checkbox"/> Chemical/Drug Dependency |
| <input type="checkbox"/> Pregnancy - months: _____ | <input type="checkbox"/> Birth control pill | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> ANY Condition Not Mentioned Above |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Heart disease/damage | |

Please elaborate on any of the above:
