PATIENT INFORMATION

PATIENT'S PERSONAL INFORMATION

Date: ________________

Name: ____ ☐ M ☐ F DOB: ________________

Address:________________________________City:________________State:______ _Zip:______________

Home Phone: (________)__________________ Work: (________)__________________ Cell: (________)__________________

Social Security Number: _________ - ______ - _________

Occupation:________________________________ Employer: ________________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Pharmacy: ________________________________

Spouse's Name:____________________________ Work Phone: (________)__________________

PATIENT'S / WORK RELATED INJURY

Is your condition a result of a work injury? ☐ YES ☐ NO Date of Injury: ________________

Is your condition a result of an auto accident? ☐ YES ☐ NO

Worker's Compensation Insurance Company Name:____

Address:__________________________City:________________State:______Zip:____________

Adjuster:________________________________ Claim #:__________________________

Phone: (________)__________________ Fax: (________)__________________

Nurse Case Manager: ____________________________

Phone: (________)__________________ Fax: (________)__________________

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

Primary Insurance Company:____

Address:__________________________City:________________State:______Zip:____________

Name of Insured: ______________________________DOB:____________ Relationship to Patient:__________________

Insurance ID Number: ______________________________ Group Number:______________________________

Secondary Insurance Company:____

Address:__________________________City:________________State:______Zip:___________

Name of Insured: ______________________________DOB:____________ Relationship to Patient:__________________

Insurance ID Number: ______________________________ Group Number:______________________________

PATIENT'S REFERRAL INFORMATION

Primary Care Physician: ________________________________ Referred By:______________________________

Assignment of Benefits ● Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Noah D. Weiss, M.D., and any assisting physicians, for services rendered. I understand that I am financially responsible for all changes whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:____ **Date:**________________

Method of Payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

PATIENT INFORMATION

PATIENT INFORMATION

Date: ______________

Name: _______________________________________ □ M □ F Age: ______ DOB: _____________

Height: _________ Weight: ________ Dominant Hand: □ R □ L

Who Referred you to this practice? ____

Email Address: ____

HISTORY OF INJURY

Area of Problem or Injury/ Body Part:

Date of Injury: Onset: ☐ Gradual (came on slowly) or ☐ Sudden (happened all at once)

How Did Your Injury Occur?:

Chief Complaint and Symptoms (What bothers you?):

PATIENT INFORMATION

What makes it Worse?:

What makes it Better?:

What can you not do now that you could do before your injury?

Have you seen any other doctors about this condition? ☐ **YES** ☐ **NO**

If so, whom? Date:

____ ____________________________

____ ____________________________

____ ____________________________

Have you hand any of the following tests or studies already done? If so, when?:

☐ X-rays ☐ CT scans

☐ MRI ☐ Nerve Conduction Studies

☐ Blood tests ☐ Other tests

What type of treatment have you had so far?

☐ Brace or splint ☐ Physical therapy (Dates) ______________________________

☐ Chiropractic ☐ Injections

☐ Hospitalized ☐ Surgery (What kind) _________________________________

☐ Other ____

☐ Medications ____

PATIENT INFORMATION

HISTORY OF PREVIOUS INJURY

Have you injured this body part before? ☐ **YES** ☐ **NO** If Yes, when? ________________________

What were your symptoms prior to this injury?

PAST MEDICAL HISTORY

General Status of Health: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Have you ever had any of the following?

☐ Diabetes I or II ☐ Bleeding Problems ☐ Malignancies, Cancer ☐ Asthma
☐ Arthritis ☐ High blood pressure ☐ Neurological Problems ☐ Angina
☐ Thyroid disorder ☐ High Cholesterol ☐ Hormone Disorder ☐ Epilepsy
☐ Heart attack ☐ Frequent Heartburn ☐ Hereditary Problems ☐ Hiatal Hernia
☐ Kidney Disease ☐ Psychiatric Illness ☐ Irregular heartbeats ☐ Eating Disorder
☐ Emphysema ☐ Gout ☐ Reynaud's Disease ☐ Hepatitis, Liver Disease
☐ Other Illnesses or Injuries: ____
____

Primary Care Physician: ____

PAST SURGICAL HISTORY

☐ **NONE**

Type of Surgery	Doctor	Hospital	Approximate Date

PATIENT INFORMATION

ALLERGIES

Are you allergic to any type of drug or medicine? ☐ **YES** ☐ **NO**

If yes, please list and include symptoms:

Are you allergic to Latex? ☐ **YES** ☐ **NO**

MEDICATIONS AND DIETARY SUPPLEMENTS

☐ **NONE**

Medication	Dosage/Frequency

PATIENT INFORMATION

FAMILY HISTORY

Do any of the following medical conditions run in your family?

☐ High Blood Pressure ☐ Cancer (what kind?) ________________________

☐ Diabetes ☐ Other: ___________________________________

☐ Unknown ☐ None

SOCIAL HISTORY

Language: ☐ English ☐ Spanish ☐ Other: ________________

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed

Do you have any children? If so, how many and what age? ____

Do you smoke cigarettes?:

☐ Yes: How many packs per day?:_____________ For how many years:_________________

☐ Former Smoker: When did you quit?:_________________

☐ Never Smoked

Do you drink alcohol?:

☐ Yes: ☐ Social/Occasional Drinker ☐ Daily How many drinks per day?:________________

☐ No, I don't drink any alcohol

Other drugs: ____

Sports, Hobbies, Other jobs:

Occupation: Employer:

Current Work Status: Last Date Worked:

REVIEW OF SYSTEMS

Do you have any of the following?

☐ Headaches	☐ Shortness of Breath	☐ Recent unexplained weight loss
☐ Vision Problems	☐ Stomach Ache	☐ Morning Stiffness
☐ Ringing in Ears	☐ Burning Urination	☐ Joint to joint pain
☐ Hearing Loss	☐ Coughing up blood	☐ Numbness, tingling
☐ Sore Throat	☐ Blood in bowel movements	

Is there anything else regarding your health that we should know when treating you?

____

____

____

The above is accurate to the best of my knowledge.

Signature: ____ **Date:** __________

Worker's Compensation Patients Information ONLY!

WORKER'S DISABILITY HISTORY

Adjuster: ______________________________ Claim No.: ___________________________

Occupation or Job Title: ____

Employer: ____

Employer's Address: ____

City ______________________ State _________ Zip Code ___________

Date you started working for this employer: ___________

What day was the injury reported?: ______________ To whom? __________________________

At the time of injury, were you working: ☐ Full time ☐ Part time

Describe your job's physical activities and requirements:

Before this injury, did you have any restrictions? ☐ **YES** ☐ **NO** If so, what?

After your injury, were you placed on Modified or Limited/Light duty? ☐ **YES** ☐ **NO**

If so, what periods? What restrictions?

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Were you ever taken off work (Temporary Disability) □ Yes □ No If so, when? ___________________

Since the original injury, have you re-injured the same area? ☐ **YES** ☐ **NO**

If yes, how and when?:

Did you have any other part-time jobs? ☐ **YES** ☐ **NO**

Previous Jobs: Dates Job Title Employer

__________________________ ______________________________ __________________________

__________________________ ______________________________ __________________________

__________________________ ______________________________ __________________________

Are you currently working for the same employer?

☐ Yes ___Regular Duty ___Part Time ___Limited/Light Duty

☐ No ___Quit ___Was fired ___Laid off for medical reasons ___Laid off for non-medical reasons

Are you currently working for a different employer? Who and what type of job? ______________________

____

☐ Yes ___Regular Duty ___Limited/Light Duty

☐ No