

# INTRODUCTION PATIENT CASE HISTORY

Today's Date: \_\_\_ / \_\_\_ / \_\_\_

## PATIENT INFORMATION

Name: (First MI Last) \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender:  Male  Female Social Security #: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred Method of Contact:  Text  Email  Phone - Home, Mobile, or Work  Other: \_\_\_\_\_

**\*Referred By:** (Name) \_\_\_\_\_

Family  Friend  Co-Worker  Doctor  Other: \_\_\_\_\_

**Race & Ethnicity:** (Choose up to 2)

- African American or Black
- American Indian or Alaskan Native
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Decline

**Preferred Language:**

- English
- Spanish
- Other: \_\_\_\_\_
- Decline

## EMERGENCY CONTACT INFORMATION

Name: (First MI Last) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Home: \_\_\_\_\_ Mobile: \_\_\_\_\_

Doctor's Phone: \_\_\_\_\_

Relationship:

Child  Parent  Spouse  Other: \_\_\_\_\_

## FINANCIAL INFORMATION

**Is today's visit the result of an accident?**

No  Auto  Work  Other: \_\_\_\_\_

**Where would you like statements sent?**

Self  Other (Details below)

**Will we be working with insurance?**  No  Yes (Details)

Name: \_\_\_\_\_

Primary: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Secondary: \_\_\_\_\_ ID#: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I have answered these questions to the best of my knowledge and certify them to be true and correct.

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

Account No: \_\_\_\_\_