Palm Harbor® SPINE CENTER

PATIENT INFORMATION

Date_____

SS/HIC/Patient ID#_____

Patient Name_____
Last Name

_____
First Name Middle Initial

Address_____

City _____

State_____ Zip_____

Number of Children_____

Sex ☐M ☐F Age_____

Birth date_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_____years

Occupation_____

Patient Employer/School _____

Employer/School Address_____

_____

Employer/School Phone (____) _____

Spouse's Name_____

Birth date_____

SS#_____

Spouse's Employer_____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship_____

Phone (____) _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐Yes ☐ No

Subscriber's Name_____

Birth date_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with and

_____
Name of Insurance Company (ies)

And assign directly to Dr. Amar Patel all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal representative

_____
Please print name of Patient, Parent, Guardian or Personal representative

_____ _____
Date Relationship to Patient

ACCIDENT INFORMATION

Is condition due to an accident? ☐Yes ☐ No

Date_____

Type of accident ☐ Auto ☐Work ☐ Home ☐Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐Worker Comp. ☐Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐Yes ☐ No ☐Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

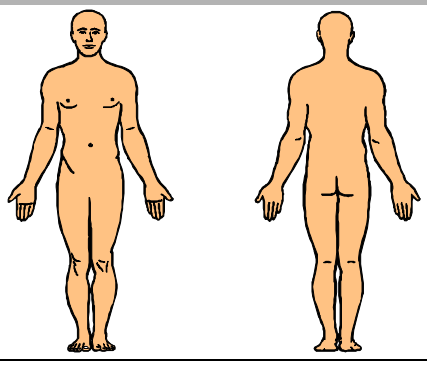
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pan: ☐Sharp ☐Dull ☐Throbbing ☐Numbness ☐Aching ☐Shooting
☐Burning ☐Tingling ☐Cramps ☐Stiffness ☐Swelling ☐Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your? ☐ Work ☐Sleep ☐ Daily Routine ☐ Recreation



Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐Chiropractic Services ☐None ☐Other_____

Name and address of other doctor(s) who have treated you for your condition_____

Date of last: Physical Exam _____Spinal X-Ray _____Blood Test_____

Spinal Exam _____Chest X-Ray _____Urine Test_____

Dental X-Ray _____MRI, CT-Scan, Bone Scan_____

Place a mark on "Yes" or "No" to indicate if you have any of the following:

AIDS/HIV	☐Yes ☐ No	Chicken Pox	☐Yes ☐ No	Liver Disease	☐Yes ☐ No	Rheumatoid Arthritis	☐Yes ☐No
Alcoholism	☐Yes ☐ No	Diabetes	☐Yes ☐ No	Measles	☐Yes ☐ No	Rheumatic Fever	☐Yes ☐No
Allergy Shots	☐Yes ☐ No	Emphysema	☐Yes ☐ No	Migraine Headaches	☐Yes ☐ No	Scarlet Fever	☐Yes ☐No
Anemia	☐Yes ☐ No	Epilepsy	☐Yes ☐ No	Miscarriage	☐Yes ☐ No	Stroke	☐Yes ☐No
Anorexia	☐Yes ☐ No	Fractures	☐Yes ☐ No	Mononucleosis	☐Yes ☐ No	Suicide Attempt	☐Yes ☐No
Appendicitis	☐Yes ☐ No	Glaucoma	☐Yes ☐ No	Multiple Sclerosis	☐Yes ☐ No	Thyroid Problems	☐Yes ☐No
Arthritis	☐Yes ☐ No	Goiter	☐Yes ☐ No	Mumps	☐Yes ☐ No	Tonsillitis	☐Yes ☐ No
Asthma	☐Yes ☐ No	Gonorrhea	☐Yes ☐ No	Osteoporosis	☐Yes ☐ No	Tuberculosis	☐Yes ☐ No
Bleeding Disorders	☐Yes ☐ No	Gout	☐Yes ☐ No	Pacemaker	☐Yes ☐ No	Tumors, Growths	☐Yes ☐ No
Bulimia	☐Yes ☐ No	Heart Disease	☐Yes ☐ No	Parkinson's Disease	☐Yes ☐ No	Typhoid Fever	☐Yes ☐ No
Cancer	☐Yes ☐ No	Hepatitis	☐Yes ☐ No	Pinched Nerve	☐Yes ☐ No	Ulcers	☐Yes ☐ No
Cataracts	☐Yes ☐ No	Hernia	☐Yes ☐ No	Pneumonia	☐Yes ☐ No	Whooping Cough	☐Yes ☐ No
High Cholesterol	☐Yes ☐ N	Herniated Disc	☐Yes ☐ No	Prostate Problem	☐Yes ☐ No	Other_____	

EXERCISE	**WORK ACTIVITY**	**HABITS**	
☐ None	☐ Sitting	☐ Smoking	Packs/Day_____
☐ Moderate	☐ Standing	☐ Alcohol	Drinks/Week_____
☐ Daily	☐ Light Labor	☐ Coffee/ Caffeine Drinks	Cups/Day_____
☐ Heavy	☐ Heavy Labor	☐ High Stress Level	Reasons_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS