CONFIDENTIAL PATIENT INFORMATION

PERSONAL INFORMATION

NAME: _____
LAST FIRST MIDDLE

HOME ADDRESS: _____
STREET CITY STATE ZIP CODE

HOME PHONE: _____ DATE OF BIRTH: _____ AGE: _____

CELL#: _____ SSN: _____ SEX: MALE / FEMALE

EMERGENCY CONTACT AND PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

SPOUSE'S NAME: _____ WORK PHONE: _____

INSURANCE INFORMATION:

AUTO OR HEALTH INSURANCE (CIRCLE ONE)

PRIMARY INSURED PARTY: _____ RELATIONSHIP: _____

INSURANCE COMPANY: _____ INSURANCE PHONE: _____

ADDRESS: _____

POLICY #: _____ CLAIM #: _____

SECONDARY INSURED PARTY: _____ RELATIONSHIP: _____

INSURANCE COMPANY: _____ INSURANCE PHONE: _____

ADDRESS: _____

POLICY #: _____ CLAIM #: _____

MEDICAL INFORMATION:

REASON FOR TODAY'S VISIT? _____

WHAT ARE YOUR SYMPTOMS? _____

WAS THIS ACCIDENT: ( ) AUTOMOBILE ( )JOB INJURY ( ) OTHER

DATE OF ACCIDENT OR INJURY: _____

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PAST MEDICAL HISTORY: HAVE YOU EVER BEEN TREATED FOR:

	NO	YES		NO	YES
ANEMIA			HIGH BLOOD PRESSURE		
ULCER			CANCER		
ASTHMA			EPILEPSY		
STROKE			DIABETES		
BLEEDING DISORDER			HEART ATTACK		
HIV/AIDS			EMPHYSEMA		
LIVER PROBLEMS			KIDNEY PROBLEMS		
HEART DISEASE / ANGINA			ALCOHOL OR DRUG ABUSE		

ARE YOU CLAUSTROPHOBIC? ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO IF YES HOW MANY PACKS PER DAY? _____

CURRENT MEDICATIONS:

NAME OF MEDICATION(S)	TAKEN FOR

ALLERGIES:

_____

_____

SURGERIES:

_____

_____

FAMILY HISTORY: PLEASE LIST ANY SERIOUS ILLNESS THAT HAVE OCCURRED IN YOUR FAMILY:

CANCER	☐ YES ☐ NO	LOCATION OF CANCER: _____	RELATION: _____
HEART DISEASE	☐ YES ☐ NO	RELATION: _____	
HIGH BLOOD PRESSURE	☐ YES ☐ NO	RELATION: _____	
STROKE	☐ YES ☐ NO	RELATION: _____	
DIABETES	☐ YES ☐ NO	RELATION: _____	
INTERCRANIAL ANEURYSM	☐ YES ☐ NO	RELATION: _____	
BRAIN TUMOR	☐ YES ☐ NO	RELATION: _____	
OTHER SERIOUS ILLNESSES	☐ YES ☐ NO	RELATION: _____	

PLEASE SPECIFY : _____

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REVIEW OF SYSTEMS: DO YOU CURRENTLY, OR HAVE YOU HAD PROBLEMS WITH:

GLAUCOMA	☐ YES	☐ NO	
WEARING HEARING AIDS	☐ YES	☐ NO	DATE OF LAST EXAM: _____
HEARING LOSS	☐ YES	☐ NO	
RINGING IN THE EARS	☐ YES	☐ NO	☐ LEFT ☐ RIGHT ☐ BOTH
BALANCE DISTURBANCE (e.g. VERTIGO, SPINNING)	☐ YES	☐ NO	
CHEST PAIN OR ANGINA	☐ YES	☐ NO	
HIGH BLOOD PRESSURE	☐ YES	☐ NO	
HEART MURMUR	☐ YES	☐ NO	
HIGH CHOLESTEROL	☐ YES	☐ NO	
ASTHMA	☐ YES	☐ NO	
BRONCHITIS	☐ YES	☐ NO	
EMPHYSEMA	☐ YES	☐ NO	
NAUSEA	☐ YES	☐ NO	
LIVER DISEASE	☐ YES	☐ NO	
ABDOMINAL PAIN	☐ YES	☐ NO	
BROKEN BONES	☐ YES	☐ NO	LIST: _____
BACK PAIN	☐ YES	☐ NO	
JOINT PAIN OR SWELLING	☐ YES	☐ NO	
ARM OR LEG PAIN / WEAKNESS	☐ YES	☐ NO	
ARTHRITIS	☐ YES	☐ NO	WHERE: _____
SKIN DISEASE	☐ YES	☐ NO	WHERE: _____
DOUBLE OR BLURRED VISION	☐ YES	☐ NO	
SEIZURES	☐ YES	☐ NO	
FAINTING SPELLS OR "BLACKING OUT"	☐ YES	☐ NO	
ANXIETY	☐ YES	☐ NO	
DEPRESSION	☐ YES	☐ NO	
DIABETES	☐ YES	☐ NO	
ANEMIA	☐ YES	☐ NO	
BRUSING EASILY	☐ YES	☐ NO	
T.B.	☐ YES	☐ NO	

CANCER INFORMATION

LUNG CANCER	☐ YES	☐ NO	DATE OF LAST CHEST X-RAY: _____
COLON CANCER	☐ YES	☐ NO	
PROSTATE CANCER (MALES)	☐ YES	☐ NO	
ENDOMETRIOSIS (FEMALES)	☐ YES	☐ NO	
UTERINE OR CERVICAL CANCER (FEMALES)	☐ YES	☐ NO	
BREAST CANCER	☐ YES	☐ NO	
SKIN CANCER	☐ YES	☐ NO	

ANY OTHER ACTIVE (MILIGNANT) CANCER _____

CONFIDENTIAL PATIENT INFORMATION

ATTORNEY INFORMATION:

ATTORNEY NAME: _____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE #: _____ FAX #: _____

I UNDERSTAND THAT THIS OFFICE WILL PREPARE MY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I PERMIT DR. CRIS E. LANGHEIER TO ENDORSE MY NAME TO ANY CHECK WRITTEN IN BOTH OUR NAMES, WHERE AS SUCH A CHECK IS PAYMENT FOR SERVICES REGARDING MY INJURY. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT.

PATIENT SIGNATURE: _____ DATE: _____

OR

GUARDIAN'S SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____