

PATIENT INFORMATION

PATIENT NAME _____ PHONE _____

ADDRESS _____

SEX M F DATE OF BIRTH: _____ AGE: _____ S.S.# _____ MARRIED SINGLE DIV. WID.

WEIGHT _____ HEIGHT _____

SEEN PREVIOUSLY IN THIS OFFICE? YES NO IF YES, APPROXIMATE DATE _____ HOW LONG? _____ MONTHS _____ YRS.

EMPLOYER _____
(Name & Address)

OCCUPATION _____ PHONE _____

EMERGENCY CONTACT _____
(Name & Address)

NAME OF INSURANCE _____ POLICY # _____

NAME OF SUBSCRIBER _____ RELATIONSHIP TO PATIENT: _____

MEDICAL HISTORY

ORTHOPEDIC PROBLEM _____

DATE SYMPTON 1ST APPEARED _____ ALLERGIES _____

ACCIDENT? _____ JOB INJURY AUTO OTHER _____ DATE OF ACCIDENT _____

OTHER ILLNESSES UNDER TREATMENT _____

MEDICATIONS TAKEN REGULARLY _____

DO YOU SMOKE? YES NO DRINK ALCOHOLIC BEVERAGES? YES NO HISTORY OF DRUG ABUSE? YES NO

SURGERIES IN THE PAST (DATES) _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

IF SEEN IN HOSPITAL OR ER, NAME OF HOSPITAL, DOCTOR AND DATE SEEN:

(Hospital Name)

(Doctor)

(Date)

OFFICE USE ONLY

DATE OF SURGERY: _____

DATE OF SURGERY: _____

PROCEDURE: _____

TREATMENT AND FINANCIAL AGREEMENT: I hereby apply for treatment by the above physicians and/or their assistants. Such treatment to include X-rays, injections, and such other office procedures as they deem necessary. I accept full responsibility for any charges incurred for services rendered to me. **INSURANCE ASSIGNMENT:** This will authorize the filing of any insurance in force and the direct payment to: **DR. JOSE JAEN** of any amounts due on my claim under the above stated policy (policies). I understand that I am financially responsible for charges not covered by benefits due under this authorization.

_____ Date

_____ Witness

_____ Signature of Patient or Next of Kin if Minor