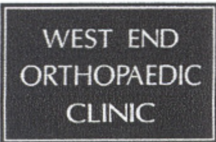

Patient Check-in Form

Name of Physician to see today ______________________________

Name of Physician who sent you here today ______________________________

Name of your Family Practice doctor ______________________________

Body Area being seen for today ______________________________
(i.e. right leg, left hip, etc.)

Problem? Y N Date problem began __________

Injury? Y N Date of injury __________

Work Injury? Y N Date of injury __________

Auto Accident? Y N Date of Accident ________ State of Accident ____

****

Patient name ________________ ____ ________________
First M Last

Address ______________________________

____

Phone (If child, phone numbers for parent)

Home (___)__________ Office (___)__________ Cell (___)__________

Date of Birth ___/___/_____ SSN ________________

Marital Status _____ Sex ____ Occupation ________________

Employer ______________________________

Employer Address ______________________________

____
City State Zip

Employer Phone (____)________________

Emergency Contact(s) ______________________________

____
Name Phone #

****

Primary Insurance Name ______________________________

Subscriber's Name (policy holder) ______________________________

Date of Birth of Policy holder __/___/_____

Relationship of Policy holder to patient ______________________________

Secondary Insurance Name ______________________________

Subscriber's Name (policy holder) ______________________________

Date of Birth of Policy holder __/___/_____

Relationship of Policy holder to patient ______________________________