

# Personal History

## Patient Information

Chart # \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
First MI Last M D Y

Name of Parent(s) (if patient is a dependent) \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work Phone # \_\_\_\_\_ Patient's SSN \_\_\_\_\_ Sex M F

E-Mail \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip

Is Injury/Illness Related to  Auto Accident  Work  Other (accident) *If yes, must complete additional forms*

Occupation \_\_\_\_\_  
(If retired, prior occupation)

Marital Status  Married  Single  Widowed  Divorced

Spouse Name \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone # \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone # \_\_\_\_\_

How did you hear about us?

Mail  Newspaper Ad  Promotional Call  Radio  Insurance

Yellow Pages  Sponsored Event  Health/Senior Fair  Website  Employer

Referred by Friend \_\_\_\_\_

Referred by Physician \_\_\_\_\_

Other \_\_\_\_\_

Reason for Appointment \_\_\_\_\_

Turn over...

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## Your Experience

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Adequate parking	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Convenience of appointment times	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Friendly greeting	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor
Clean and welcoming environment	<input type="checkbox"/> Excellent	<input type="checkbox"/> Average	<input type="checkbox"/> Poor

What can we do to make your next visit more comfortable?

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## Insurance Information

**Please give your insurance information to our front office staff so we can make a copy for our records.**

**\*\*\*\*\*PLEASE READ CAREFULLY AND SIGN BELOW\*\*\*\*\***

- I have read all the information on this sheet, completed the above answers, and certify this information is true and correct to the best of my knowledge and hereby give permission to my AudigyCertified™ practice to release information, verbal and written, contained in my medical record and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, related healthcare providers, assignees and/or beneficiaries and all other related persons. Information without patient identifiers may be used for quality purposes. I give my AudigyCertified practice permission to treat my concerns.
- I acknowledge I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

**I have read and understand all the above information.**

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A copy of this signature is as valid as the original

Date

Signature of Parent or Guardian \_\_\_\_\_