# INTRODUCTION PATIENT CASE HISTORY

**Today's Date: _____**

## PATIENT INFORMATION

**Name:** (Last, First MI)_____ **Preferred Name**: _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home:** _____ **Mobile:** _____ **Mobile Carrier:** _____ **Work:** _____

**Email:** _____ **Gender:** M / F **Marital Status:** Married / Other / Single

**Social Security #**:_____ **Date of Birth:** _____

**Student Status:** Full Student / Part Student / Non-Student ☐ **Employed** **Employer:** _____

***Referred By:** _____

**Ethnicity**: Hispanic or Latino / Other **Preferred Language:** _____

**Race:** Asian / African Am. / Am. Indian or Alaskan Native / Other / Native Hawaii or Pacific Island / White

**Smoking Status**: Every Day / Some Days / Former / Never

## EMERGENCY CONTACT INFORMATION

**Full Name:** _____ **Primary Care Physician:** _____

**Home:** _____ **Mobile:** _____ **Doctor's Phone:** _____

**Relationship**: Child / Parent / Spouse / Other: _____

## FINANCIAL INFORMATION

☐ Insurance ☐ Worker's Comp ☐ Self-Pay (Cash) ☐ Personal Injury/Auto ☐ Other (please explain):_____

**PRIMARY INSURANCE**

**Name:** _____

**Relation to Insured:** Self / Spouse / Parent / Child / Other

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Date of Birth:** _____

**SECONDARY INSURANCE**

**Name:** _____

**Relation to Insured:** Self / Spouse / Parent / Child / Other

*Other than Self:*
**Insured's Name**: _____ **Gender:** M / F

**Address**: _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone:** _____ **Date of Birth:** _____

**Who is responsible for payment?** Self / Other - *(Relationship)* _____

*Other than Self:*
**Full Name**: _____ **Phone:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

***It is Usual and Customary to Pay for Services as Rendered Unless Otherwise Arranged***

**Patient No:** _____