



Today's Date: _____

First Name: _____

Middle Initial: _____

Last Name: _____

Nickname: _____

Address: _____

City: _____

State: _____

Zip: _____

Social Security #: _____

Gender: Male Female

Marital Status: S M D W

Spouse Name: _____

Your Date of Birth: _____
Age _____

Home Phone: _____

Work Phone: _____

Ext: _____

Cell Phone: _____

Fax #: _____

Cell Phone Carrier: _____

Beeper #: _____
Pin# _____

Primary Contact: Cell Home Work Text

Secondary Contact: Cell Home Work Text

Email: _____

Emergency Contact

Name: _____

Phone: _____

Address: _____

City _____ State _____

Zip: _____

Referred

By: _____

Your Occupation: _____
Employer: _____

Employer Address: _____
Employed: Full Time Part Time Other

Is your current condition or symptom, due to an auto or work related injury?
 No Yes-Auto Yes-Work Maybe

Do you have health insurance? Yes No

Insurance Company

Name: _____

Policy ID #: _____

Group#: _____

Policy Holder

Name: _____

Date of Birth: _____

What is your relationship to the policy holder?
 Self Spouse Child

Do you have a secondary/ another insurance?
 Yes No

Other Insurance Company

Name: _____

Policy ID #: _____

Group#: _____

Policy Holder

Name: _____

Date of Birth: _____

What is your relationship to the policy holder?
 Self Spouse Child

Ages of Children: _____

Spouse's Occupation: _____

Spouse's Employer: _____



Primary Care Physician

Name: _____

Phone: _____

Your Dominant Hand: Right Left Both

1. Date of Onset: _____

2. Description of Onset:

How many treatments received? _____

Currently treating? Yes No

Did treatments benefit you? Yes No

Last visit date: _____

2. Dr. _____

First visit date: _____

Fill in other doctor(s) seen for this condition, prior to your first visit to this office.

1. Dr. _____

First visit date: _____

Specialty _____

Specialty _____

X-rays done? Yes No

Types of treatments received: _____

How many treatments received? _____

Currently treating? Yes No

Did treatments benefit you? Yes No

Last visit date: _____

Describe your condition during and immediately after Onset

X-rays done? Yes No

Types of treatments received: _____

Have you been treated for any other health condition by a physician in the last year?



Yes, describe: _____

No

List any serious illness you have had and when:

List all surgeries you've had and when:

What medications are you currently taking?

FINANCIAL ARRANGEMENTS: I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care, as determined by my treating doctor, any fees for professional services will be immediately due and payable. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office.

ASSIGNMENT OF BENEFITS: I authorize direct payment of medical benefits to this office and release of medical information necessary to process my insurance claims.

APPOINTMENT CANCELTION: I understand that Dopps on West Central charges \$35, if they are not notified of appointment cancellation, prior to scheduled appointment time.

CONSENT TO TREATMENT: I voluntarily consent to the rendering of care, including treatment and performance of diagnostic

procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

NOTICE OF PRIVACY PRACTICES: I certify that I have received a complete copy of Dopps' Notice of Privacy Practices. By signing this form, you are granting consent to Dopps to use and disclose your protected information for the purposes of treatment, payment and health care operations. We encourage you to read the Notice of Privacy Practices, in full.

Patient's Signature:

Today's Date:

VERIFICATION OF NON-PREGNANCY (Female Patients Only):

Are you pregnant?

Yes

No Date of LMP _____

Maybe

Trying

I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Signature: _____


