San Antonio Accident Doctor - New Patient Intake Form

Name: _____

Street Address: _____ City: _____State: ____ Zip Code: _____

Phone: _____Work:_____email:_____

Occupation: _____ Employer's Name: _____

Date of Birth: _____ SSN#: _____

Marital Status (check one): ___Single ___Married ___Widowed ___Separated ___Divorced

Number of Children: _____ Ages: _____

Name of Emergency Contact: _____Phone#: _____

Patient's Statement of Injury: _____

_____

_____

What is condition related to? (check one) ____ Auto Accident ____ Employment ____ Other

Date of accident/injury: _____ Pain was (check one) _____Immediate _____Gradual

Have you ever had same or similar symptoms? (check one) ___Yes ___No

Describe: _____

Lost work time? (check one) ___Yes ___No. If yes, date you returned to work: _____

Were you referred by another physician? (check one) ___Yes ___No

If yes, name: _____

Have you seen another doctor for this condition? (check one) ___Yes ___No

Describe: _____

What medications or drugs are you taking? _____

Are you pregnant? (check one) ___Yes ___No

Insurance Information (check one) ___Major Medical ____Personal Injury (Auto) __Medicare __Medicaid ____Workman's Comp (Job Injury) ____Other

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I understand and agree to authorize Ross Family Clinics, PLLC (and all employees to administer whatever examination procedures and treatments they deem necessary.

Patient's Signature: _____ Date: _____

Guardian (if patient is under 18 years old) _____Date: _____

Sign Authorizing Care