POSTURE PERFECT WELLNESS CENTER
PATIENT INFORMATION

Appt. Date _____ Doctor you are here to see _____ (please print)

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____ Age _____ Sex _____

Marital Status S M D W (Circle One) Spouses Name _____

Home Phone _____ Cell Phone _____

Employer _____ Work Address _____

City/State _____ Zip _____ Work Phone _____

Email _____ Drivers License # _____

Emergency Contact _____ Phone _____

How were you referred to this office? _____

Is this injury related to: Auto Accident Work Injury Other Accident Illness Unknown cause

What is your major complaint? _____

Are the symptoms: Improving Getting Worse About the Same Come and Go

Date of Illness/Injury _____ Date Symptoms Appeared _____

Have you had these symptoms before? _____ If so, when? _____

Have you seen another doctor for this illness/injury? Doctor's name and specialty _____

INSURANCE INFORMATION

Do you have health insurance? _____ Name of Provider _____

Address _____ Phone _____

Insured's Name _____ Relation to patient _____

Insured's date of birth _____ SS# _____

Require a Referral Yes No Copay _____ Group # _____

Are you covered under any other health plan through yourself or your spouse? _____

IF YOUR INJURY WAS AUTO OR WORK RELATED COMPLETE THE FOLLOWING INFORMATION

Patient's Auto/Work Comp Insurance Co. _____ Policy #_____

Claim # _____ Phone # _____ Adjuster's Name _____

Address _____ Uninsured Motorist Coverage? Yes No

PIP Coverage? Yes No Med Pay Coverage? Yes No Attorney's Name _____

Attorney's Phone _____ Other Insurance Carriers Involved _____