Patient #: ____________

Today's Date: ___________

Patient Information Form

Full Name: ______________________________________ **SSN**: _________________
First Middle Last

Temporary Address: ____
Street City State Zip

Permanent Address: ____
Street City State Zip

Circle One:
Single Married Divorced Widowed

Circle One:
Student Employed Other

Home Phone#:______________________**Work Phone #**: ______________________

Cell Phone #:_____________________ **Date of Birth**: _______________Age: ______

E**mployer**: ____________________________**Occupation**: _______________________

Employer Address: ____
Street City State Zip

Contact Information in case of emergency:

____
Name Relationship Phone Number

GUARANTOR INFORMATION:

(Only fill out this section if different from patient)

Guarantor's Name: ____ **Sex**: _______
First Middle Last

Address: ____
Street City State Zip

Home Phone#:______________________**Work Phone #**: ______________________

Cell Phone #:_____________________ **Date of Birth**: _______________Age: ______

Guarantor's E**mployer**: _______________________**Occupation**:_________________

Relationship to patient: ____

INSURANCE INFORMATION:

Primary Insurance: ____

Policy Holder: ________________________ Relationship to patient_________________

Address: ____
Street City State Zip

Phone #: _________________ **ID #**: ___________________ **Group #**: _______________

Effective Date: _____________________ **Termination Date**: ____________________

Secondary Insurance: ____

Policy Holder: ________________________ Relationship to patient_________________

Address: ____
Street City State Zip

Phone #: _________________ **ID #**: ___________________ **Group #**: _______________

Effective Date: ____________________ **Termination Date**: _____________________

TREATMENT INFORMATION:

Injury Area: ____

Employment Related? ____________________ **Accident Related**? ________________

Date of Onset/Injury: _____________________ **Date of 1st Dr. Visit**: _______________

Referral Physician: _______________________ **Date of Next Dr. Visit**: _____________

Surgeon (if applicable): ____

MEDICAL INFORMATION:

Have you had previous therapy for the condition for which you are receiving treatment here? Yes No

If yes, when and where? ____

Are you currently under medical care for any other problems? Yes No

If yes, please describe: ____

Are you currently taking any prescription or over the counter medications?

Yes No

List medications: ________________ ________________ ________________

________________ ________________ ________________ ________________

Do you now have/or have you had any of the following? Circle all that apply.

Diabetes	yes	no	Allergies to Heat/Ice	yes	no
High Blood Pressure	yes	no	Are you pregnant?	yes	no
Heart Disease	yes	no	Other Allergies	yes	no
Heart Attack	yes	no	Previous Surgery	yes	no
Pacemaker	yes	no	Headaches	yes	no
Seizures	yes	no	Kidney Problems	yes	no
Metal Implants	yes	no	Nervous Disorders	yes	no
Hernia	yes	no	Circulatory Disorders	yes	no
History of Cancer	yes	no	Stroke	yes	no
Total Joint Replacement	yes	no	Osteoporosis	yes	no
Congestive Heart Failure	yes	no	Back or Neck Pain	yes	no

Have you had a CAT scan, X-rays or MRI for this problem? Yes No

If yes, which one and dates? ____

How did you hear about our clinic?

____

I have received a copy of and understand the Great Plains Therapy, Inc. Uses and Disclosures of Health Information HIPAA General Operating Policy. I also, have received a copy of and understand the Great Plains Therapy, Inc. rules and agree to abide by them.

This information is correct to the best of my knowledge.

Signature ___________________________________ Date ____________________