

Date \_\_\_\_\_

CONFIDENTIAL PATIENT INFORMATION

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital: M S W D How Many Children \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_ Office Phone \_\_\_\_\_

Name of Wife or Husband \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Office Phone \_\_\_\_\_

Patient's Nearest Relative \_\_\_\_\_ Phone \_\_\_\_\_

Referred By: \_\_\_\_\_

Date of Last Physical Examination \_\_\_\_\_

What Operations Have You Had? \_\_\_\_\_ When? \_\_\_\_\_

Have You Ever Suffered From:

- |                        |                    |                              |
|------------------------|--------------------|------------------------------|
| 1. Dizziness _____     | 5. Headaches _____ | 9. Digestive Disorders _____ |
| 2. Backaches _____     | 6. Numbness _____  | 10. Nervousness _____        |
| 3. Heart Trouble _____ | 7. Asthma _____    | 11. Sinus Trouble _____      |
| 4. Arthritis _____     | 8. Neuritis _____  | 12. Cancer _____             |

Purpose of This Appointment: \_\_\_\_\_

Other Doctors Seen for This Condition \_\_\_\_\_

Have You been treated for any health condition by a physician in the last year? YES NO

Describe \_\_\_\_\_

What medications or drugs are you taking? \_\_\_\_\_

Have you ever been injured in an auto accident? \_\_\_\_\_ Date? \_\_\_\_\_

Are You pregnant? \_\_\_\_\_

**PAYMENT IS EXPECTED AT TIME OF VISIT!**

Name of person responsible for payment \_\_\_\_\_

ARE YOU INSURED? YES NO COMPANY \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Dr. Scott Brodnax will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Scott Brodnax will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ S.S.# \_\_\_\_\_ Date: \_\_\_\_\_

Guardian or Spouse's \_\_\_\_\_

Signature Authorizing Care: \_\_\_\_\_ S.S.# \_\_\_\_\_ Date: \_\_\_\_\_

Information Taken By: \_\_\_\_\_ Date: \_\_\_\_\_