INITIAL EVALUATION / HISTORY

PATIENT INFORMATION

NAME: MR MRS MS DR REV _____

PHONE: H: ( )____ -_____ **SS#:** _____- ____ -_____

W: ( )____ -_____ **DOB** ____/_____/_____

ADDRESS: _____

CITY:_____ **ST** _____ **ZIP** _____

EMAIL: _____@_____ . _____

(*Please circle one*)

SEX MALE FEMALE

STATUS SINGLE MARRIED DIVORCED SEPARATED WIDOWED OTHER

CONDITION IS RELATED TO:

AUTO ACCIDENT EMPLOYMENT OTHER

ONSET:	GRADUAL	INJURY
1ST DR VISIT	DATE ___/___/20___	DATE: ___/___/20___

EMPLOYMENT

EMPLOYED FULL TIME PART TIME RETIRED

SELF- EMP NON- EMP UNKNOWN

STUDENT YES NO FT PT

CURRENT EMPLOYER: _____

PHONE: ( )____ -_____

ADDRESS: _____

CITY:_____ **ST** _____ **ZIP** _____

☐ **WC EMPLOYER AT TIME OF INJURY:** _____

PHONE: ( )____ -_____

Has injury been reported to supervisor/foreman? **Yes - No**

If yes, give his/her name_____

May I call your employer for authorization to treat you? **Yes - No**

Primary Insurance Provider

PRIMARY INS. CO : _____

PH: ( )____ -_____ **CLAIM #:**_____

ADJUSTER : _____

PLAN NAME: _____

POLICY EFFECTIVE DATE **POLICY #:**_____

_____/_____/20_____ **GROUP #:**_____

PATIENT'S RELATION TO INSURED:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED'S NAME:

PHONE: H: ( )____ -_____ **SS#:** _____- ____ -_____

W: ( )____ -_____ **DOB** ____/_____/_____

ADDRESS: _____

CITY:_____ **ST** **ZIP** _____

INSURED'S EMPLOYER: _____

ADDRESS: _____

CITY:_____ **ST** _____ **ZIP** _____

Secondary Insurance Provider

SECONDARY INS. CO: _____

PH: ( )____ -_____ **CLAIM #:**_____

ADJUSTER : _____

PLAN NAME: _____

POLICY EFFECTIVE DATE **POLICY #:**_____

_____/_____/20_____ **GROUP #:**_____

PATIENT'S RELATION TO INSURED:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED'S NAME:

PHONE: H: ( )____ -_____ **SS#:** _____- ____ -_____

W: ( )____ -_____ **DOB** ____/_____/_____

ADDRESS: _____

CITY:_____ **ST** **ZIP** _____

INSURED'S EMPLOYER: _____

ADDRESS: _____

CITY:_____ **ST** _____ **ZIP** _____

Tertiary Insurance provider

TERTIARY INS. CO: _____

PH: ( )____ -_____ **CLAIM #:**_____

ADJUSTER : _____

PLAN NAME: _____

POLICY EFFECTIVE DATE **POLICY #:**_____

_____/_____/20_____ **GROUP #:**_____

PATIENT'S RELATION TO INSURED:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

INSURED'S NAME:

PHONE: H: ( )____ -_____ **SS#:** _____- ____ -_____

W: ( )____ -_____ **DOB** ____/_____/_____

ADDRESS: _____

CITY:_____ **ST** **ZIP** _____

INSURED'S EMPLOYER: _____

ADDRESS: _____

CITY:_____ **ST** _____ **ZIP** _____