Patient Demographics

Date

Patient Information:

First Name
Middle Name / MI
Last Name
Sex
Date of Birth
Home Phone
Cell Phone
Preferred Phone
Patient Address Line 1
Patient Address Line 2
City
State
Zip
Email
Language
Communication Preference
Ethnicity
Religion
Race
Marital Status
Spouse's Name
Spouse's Contact Phone
Patient Employment Status
Professional Title
Employer Name
Work Phone
Fax Number
Employer Address Line 1
Employer Address Line 2
Employer City
Employer State
Employer Zip

Primary Insurance Information:

Primary Insured's Name
Date of Birth
Primary Relationship to Insured
Primary Insured's SSN
Insured's Home Phone
Cell Phone
Work Phone
Driver's License #
Primary Insurance Name
Primary Plan Name
Primary Subscriber ID
Primary Group No.

Secondary Insurance Information:

Secondary Insured's Name
Date of Birth
Secondary Relationship to Insured
Secondary Insured's SSN
Insured's Home Phone
Cell Phone
Work Phone
Driver's License #

Secondary Insurance Name ______

Secondary Plan Name ______

Secondary Subscriber ID ______

Secondary Group No. ______

Emergency Contact:

Emergency Contact Name ______

Emergency Contact Relationship to Patient ______

Emergency Contact Home Phone ______

Emergency Contact Cell Phone ______

Emergency Contact Work Phone ______

Emergency Contact Address Line 1 ______

Emergency Contact Address Line 2 ______

Emergency Contact City ______

Emergency Contact State ______

Emergency Contact Zip ______

Primary Physician Name ______

Primary Physician Phone ______

Whom may we thank for referring you? ______

Health History

Current medical conditions:

Month/Year Diagnosed	Medical Problem	Treatment/Medication
1)	–	–
2)	–	–
3)	–	–
4)	–	–

Surgeries:

Month/Year	Reason	Hospital
1)	–	–
2)	–	–
3)	–	–
4)	–	–

Hospitalizations:

Month/Year	Reason	Hospital
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Medications:

Name of Drug	Strength	Frequency Taken
1)	_	_
2)	_	_
3)	_	_
4)	_	_

Allergies

Name	Reaction
1)	_
2)	_
3)	_
4)	_

Exercise:

Type	Intensity	Frequency
Type	Intensity	Frequency

Social History

Caffeine:

Caffeine Beverage?

- Yes
- No

Type (coffee, tea, soda, etc.)

Amount

Frequency

Alcohol:

Alcoholic Beverage?

- Yes
- No

Frequency

Amount

Smoking Status

Patient Smoking Status

Patient Smoking Frequency

Patient Smoking Start Date

Patient Smoking End Date

Do you currently use recreational or street drugs?

- Yes
- No

Have you ever given yourself street drugs with a needle?

- Yes
- No

Family History

List medical illness and/or cause of death:

Mother

Father

Brother/Sister

Husband/Wife

Son/Daughter

Additional Comments

Date

Signature of Responsible Party

GENERAL CONSENT

I consent to evaluation and treatment of the condition for which I, my child or dependent, have come to and authorize the physicians and other health care providers affiliated with Kowin Casey/ KC Wellness and Physiotherapy, to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by Kowin Casey/ KC Wellness and Physiotherapy. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at Kowin Casey/ KC Wellness and Physiotherapy. I have had an opportunity to discuss it, and any questions I have had have been answered to my complete satisfaction.

Date

____

Signature of Patient, Parent or Legal Guardian

Date

____

Signature of Witness