PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MID INIT_____

ADDRESS _____ DATE OF BIRTH _____ AGE _____

CITY _____ SOC SEC NO. _____ SEX M ☐ F ☐

STATE _____ZIP_____ BIRTHPLACE _____ MARITAL STATUS _____

HOME PHONE _____ CELL PHONE _____ OCCUPATION _____

WORK PHONE _____ EMPLOYER _____

PERSON TO CONTACT IN AN EMERGENCY (SPOUSE, NEIGHBOR, FRIEND OR RELATIVE):

NAME _____ RELATIONSHIP _____

ADDRESS _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

INSURANCE / PAYSOURCE

PRIMARY _____ SECONDARY _____

POLICY HOLDER _____ POLICY HOLDER _____

NUMBER _____ NUMBER _____

TELEPHONE_____ TELEPHONE _____

MEDICAL INFORMATION

ALLERGIES _____ CIGARETTES: YES_____ NO _____

FAMILY / PCP / DOCTOR(S) _____ HOW MUCH? _____

LIST MEDICATIONS _____

_____

PREVIOUS SURGERY _____

MEDICAL PROBLEMS _____

I WAS REFERRED BY _____ DATE OF ONSET OR INJURY _____

REASON FOR THIS VISIT _____

SIGNATURE

By signing

I acknowledge that the above information is complete, true and correct
I authorize the release of all medical information as needed to and from Doctor Cuadros
I authorize the use of photography
I acknowledge that I am entering into a physician-patient relationship with Doctor Cuadros
I agree to comply with the care, medication, instructions and treatment prescribed to me by the doctor
I agree to be responsible for all financial charges incurred as a result of my evaluation and treatment

PATIENT SIGNATURE _____ DATE _____