Patient Information

(Please Print)

(All Patient Records Will Be Kept In Strict Confidentiality.)

We would like to welcome you to Springfield Accident & Pain Center!

How did you find out about us?

Referral ☐ Referred by: _____ Phone Book ☐ Online ☐ Facebook ☐ Walk-in ☐

Today's Date: _____

PATIENT INFORMATION

Name:			Middle Initial:
Date of Birth:		Social Security #:	
Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed			
Race/ Ethnicity:			
Height:	Weight:	Primary Care Physician:	
Address:			
City:	State:		Zip:
Home Phone:	Cell Phone:	Email:	

EMPLOYEMENT INFORMATION

Employed by:		
Occupation:	Business Phone:	
Address:		
City:	State:	Zip:

SPOUSE INFORMATION (or PARENT INFORMATION, if the patient being seen is a minor)

Name:		
Address:		
City:	State:	Zip:
Contact Number:		

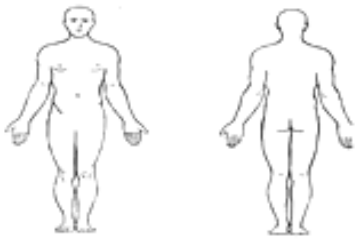
EMERGENCY CONTACT (Please put "Same" if information is identical to patient info.)

Name:
Contact Number:

How will payments be made? ☐ Cash ☐ Health Insurance ☐ Work Comp ☐ Auto Ins. Policy

Please describe your symptoms & identify their locations on the chart.

_____
_____
_____
_____
_____
_____
_____



How did your condition develop? _____

When was the date of accident or initial date of symptom(s)? _____

Have you had this problem prior to this visit? If yes, please explain: _____

Have you received treatment for this condition? If yes, where, when, and what were the results? _____

Has the problem been getting better, worse, or remained constant? _____

Have you been in an auto accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years

Do you smoke? *(Please Circle)* **YES NO** How long have you smoked/ frequency? _____

Current Medications: ☐ Birth Control ☐ Pain Killers ☐ Diet Pills ☐ Muscle Relaxers ☐ Tranquilizers ☐ Other: _____

Women Only

Are you pregnant? *(Please Circle)* **YES NO**

Patient is responsible for updating any contact information required by the clinic. In the event that it becomes necessary to turn your account over to a collection agency, you will be responsible for any and all court costs, collection agency fees up to 35% of your outstanding balance, and attorney fees, necessary to obtain a full recovery of your outstanding balance.

Patient's Signature: _____