JourneyFit

PATIENT CONFIDENTIAL INFORMATION

1. Name _____
   First Middle Last
2. Address _____
   Street City State Zip
3. Home Phone _____ 4. Preferred Phone _____
5. Email _____
6. Age _____ 7. Date of Birth _____ 8. Sex M F 9. Marital: M DP S D W

CASE HISTORY

10. Chief Complaint _____

_____

11. Complaint result of: ☐ Auto Accident ☐ Injury ☐ Job Related ☐ Other
12. Date of accident/Injury/Other ____/____/____
13. Have you seen any other doctor about this condition? _____ If yes, when? _____

    Doctor's Name _____ Phone _____
14. Have you had recent X-Rays? _____ If yes, when? _____ Area X-Rayed _____

FOR MINORS: List both parents' names, addresses and phone

_____

_____

_____

FINANCIAL ARRANGEMENTS

How do you plan to handle your account? (Check one) ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

Emergency Contact
Name:_____ Phone:_____ Relationship_____

DATED _____ PATIENT'S SIGNATURE _____
(parent's signature if patient is minor)

Referred by _____