

PATIENT INFORMATION

Name _____ Date _____ Birth date ____/____/____
 First Middle Initial Last
Address _____ City _____ State _____ Zip _____ Sex: Female Male
SS# _____ - _____ - _____ Married Widowed Single Minor Separated Divorced Partnered
Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____ Work Phone (____) _____ - _____
Do you prefer to receive calls at: Home Cell Work No Preference
Patient Employer/School _____ Occupation _____
Employer/School Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work (____) _____
Whom may we thank for referring you to us? _____
Person to contact in case of emergency _____ Phone (____) _____ - _____

Parent/Guardian Information (if applicable)

Name of person responsible for account _____ Relationship to patient _____
Phone (____) _____ - _____ Address _____ City _____ State _____ Zip _____
Name of Employer _____ Work (____) _____

Consent to Treatment of Minor (if applicable)

I, being the parent or guardian of _____, a minor, the age of _____, do hereby consent, authorize and request Dr. Kahn to administer such treatment deemed advisable, necessary or requested on the above minor. I agree to hold him free and harmless from any claims, suits for damages or complications, which may result in such treatment.
Signed _____ Date ____/____/____ Witness _____

Insurance Information

Name of insured _____ Relationship to Patient _____
Birhtdate ____/____/____ SS# _____ - _____ - _____ Name of Employer _____
Insurance Company _____ ID# _____ Group# _____
Do you have a deductible? Yes No If yes, how much is it? \$ _____ How much have you met? \$ _____
DO YOU HAVE ADDITIONAL INSURANCE? Yes No IF YES, PLEASE COMPLETE THE FOLLOWING:
Name of insured _____ Relationship to Patient _____
Birhtdate ____/____/____ SS# _____ - _____ - _____ Name of Employer _____
Insurance Company _____ ID# _____ Group# _____
Do you have a deductible? Yes No If yes, how much is it? \$ _____ How much have you met? \$ _____

Patient Condition

Reason for Visit _____ When did your symptoms appear? _____

Is condition due to an accident? Yes No Type of Accident Auto Work Date of Accident _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you have pain, numbness or tingling.

Rate the severity of your pain on a scale of 1 (least) to 10 (severe) _____

Type of pain: Sharp Dull Throbbing Numbness Shooting
 Aching Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is this pain constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

