CRESCENT HEALTHCARE

PATIENT INFORMATION (PLEASE PRINT)

Name _____ Home Phone _____ **Cell Phone** _____

Address _____Unit #_____ City _____ State _____ Zip _____

E-mail _____

Age_____ Birthdate _____ SS#_____ M____ F____ Marital Status _____ Number of Children _____

Employed By _____
Occupation_____

Business Address _____Work Phone _____

Spouse/Guardian Name _____ SS# _____

Phone _____ **Work Phone** _____ **E-mail** _____

Employed By _____ Occupation _____

In case of Emergency Contact _____ Phone _____Relationship_____

PRESENT COMPLAINT

Describe your problem

_____

Condition related: Work _____ Auto _____ Other _____ **Date of Accident** _____

Doctors Seen for this Problem/phone #

_____

Hospitalized YES _____ NO_____ If YES how many days _____ Number of Days Missed from work/school _____

PREVIOUS CARE

Surgeries/When

_____

Treated by a Physician for any Condition in the last 12 Months YES_____ NO_____

Describe Condition _____ Date of Last Physical Exam _____

Allergic to Any Medication/Foods YES_____ NO_____ What Kind _____

Taking Any Medication YES_____ NO_____ What kind/Strength_____

Smoke _____ **If so, how much** _____

Pregnant YES_____ NO_____ Date of Last Menstrual Period _____

INSURNCE INFORMATION

Primary (AUTO) Insurance _____ ID No _____ Group No_____

Address _____ Phone No _____

Insured Name _____ Birthdate _____

Secondary Insurance _____ ID No _____ Group No_____

Address _____ Phone No _____

Insured Name _____ Birthdate _____

PATIENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also authorize exams, X-Rays and/or any other procedures deemed necessary by this office. Should I become a patient, I understand that I am liable for any financial arrangements that will be made.

PATIENT'S SIGNATURE _____ Date _____

SPOUSE'S OR GUARDIAN SIGNATURE _____ Date_____