Case #_____

PATIENT INFORMATION

Welcome to our office! Please allow our staff to photocopy your insurance cards.

PLEASE PRINT CLEARLY

Marital Status: S M W D

Full name_____Age_____Birthdate_____ Gender: **M F**
Address_____City_____State_____Zip_____
Home Phone_____-_____-_____SS#_____-_____-_____Email address_____
Cell Phone _____
Employer_____Occupation_____Work Phone_____-_____-_____
Work Address_____City_____ State_____Zip_____
Primary care physician_____Physician Phone_____-_____-_____
Spouse's Employer_____Occupation_____Work Phone_____-_____-_____
City_____State_____Zip_____Insurance Company_____
Primary care physician?_____Phone_____-_____-_____
How did you find out about our office? □ Referral from_____ □ Yellow Pages
□ Other_____
Describe your current problem and how it began_____
_____
_____

Circle all which applies:

Smoking Status: Never Former Current every day smoker Current occasional smoker

Preferred Language: English French Spanish German Other: _____

Race: American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White Other_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Is this? □ Work Related □ Auto Related □ N/A Date of accident/onset _____

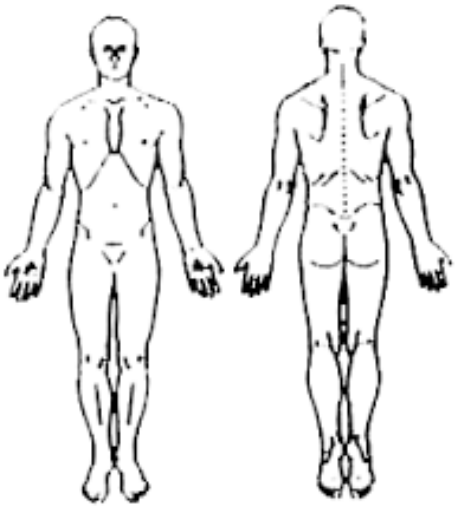
Current Complaint (How you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain → Unbearable pain

How often are your symptoms present?
□ Morning □ Noon □ Night □ Constant □ Other: _____
_____
Have you had any X-RAYS, MRI, CT SCAN? □ No □ Yes Dates_____
_____
What areas were taken? _____

Please mark X on picture where you have pain or symptoms.



READ CAREFULLY BELOW.

ACCEPTANCE AS PATIENT

I understand and agree that Dr. Joseph A. Barone, Dr. Joseph T. Barone, and Dr. Alison Roberts (Barone) have the right to refuse accepting me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient. Referral may be necessary.

PRIVACY

I authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and herby release him/her of any consequences thereof. **I (we) agree that all the above information is complete and accurate. The bottom agreements are also understood.** A photostatic copy of this agreement shall serve as the original.

I authorize the above doctors to discuss my care with my spouse. □Yes □ No □ Other _____

Patient's Signature_____Date_____

Spouse's or Guardian's Signature_____Date_____