SPINAL SOLUTIONS

101 1st Avenue East
Newton, Iowa 50208
Phone: 641-791-2323 Fax: 641-791-2229

Date: _____/_____/_____

Patient Name: ____ DOB: ______________________

Street Address: ____

City: ____________________________ State: ________________ Zip:_____________________

Home Phone: ______________________________ Cell: __________________________________

Employer Name and Address: ____

Work Phone: ______________________________

Social Security #: _________________________________ Sex: (Circle One) Male Female

Spouse's Name: ____

Emergency Contact (other than spouse) ____

Relationship to Patient: ______________________________ Phone #: ______________________

Referring Doctor: ______________________________ Family Doctor: _______________________

PATIENT INSURANCE INFORMATION

DO YOU HAVE INSURANCE? _____ Yes _____ No

1 – Primary Insurance Company Name: ____
Address/City/State/Zip____
Policy Holder's Name____
Policy Number____ Group Number______________
What relationship is policyholder to patient? (Circle) Spouse Child Self Other_____________
Is policy through Employer? If yes, employer's name____
Effective Date of Policy__________________________________ Work Phone_____________________

2 – Secondary Insurance Company Name:____
Address/City/State/Zip____
Policy Holder's Name______________________________________ DOB:_______________________
Policy Number____ Group Number______________
What relationship is policyholder to Patient? (Circle) Spouse Child Self Other_____________
Is policy through Employer? If yes, Employer's Name____
Effective Date of Policy__________________________________ Work Phone_____________________

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GENERAL HISTORY
(Please write on other side if needed)

SURGERIES:

1.
2.
3.
4.
5.

CURRENT MEDICATIONS

1.
2.
3.
4.
5.
6.

ALLERGIES TO MEDICATIONS:

(Medications) **Type of reaction:**

SOCIAL HISTORY:

Marital Status: **Single** **Married** **Divorced** **Separated** **Widow(er)** (circle one)

Occupation: ____________________

FAMILY HISTORY:

Grandmother (mom's side) ____alive ____deceased ____years old Health________________
Grandfather (mom's side) ____alive ____deceased ____years old Health________________
Grandmother (dad's side) ____alive ____deceased ____years old Health________________
Grandfather dad's side) ____alive ____deceased ____years old Health________________
Father ____alive ____deceased ____years old Health________________
Mother ____alive ____deceased ____years old Health________________
Sister/brother ____alive ____deceased ____years old Health________________
Sister/brother ____alive ____deceased ____years old Health________________
Sister/brother ____alive ____deceased ____years old Health________________

All the information that I have given you is true and correct. I understand that falsifying the information can b dangerous to my health.

Patient signature: ____________________ Date: ____________