Today's Date: ___ ___ / ___ ___ / ___ ___

TRIAD PAIN MANAGEMENT CLINIC
REHABILITATION ▲ CHIROPRACTIC CARE ▲ NON-INVASIVE SOLUTIONS

| PATIENT INFORMATION INTAKE FORM | | |
|---|---|---|
| Legal Name:<br><br>Other Name (Nickname): | Social Security #:<br><br>Birth Date : __ __/__ __ / __ __ __ __ | Sex: ☐Male ☐Female<br><br>Marital Status: ☐Married ☐Single ☐Partner |
| Address: | Home Phone:<br>Mobile/cell Phone:<br>Work Phone:<br>E-mail: | May we contact you via e-mail or cell phone? ☐Yes ☐No<br>May we leave a message at home with other residents? ☐Yes ☐No<br>May we leave personal health information on your voicemail? ☐Yes ☐No |
| Employer: | Employer Address: | Primary Care Physician:<br><br>Phone #: |
| Name of Spouse: | Spouse Employer: | Spouse Employer Phone: |
| Landlord (if Renting):<br><br>Phone #: | How did you hear about us?<br>☐Triad Web-site<br>☐Physician Referral: _____<br>☐Family/Friend: _____<br>☐Other: _____ | Reason for Visit: |
| Emergency Contact:<br><br>Relationship to patient:<br><br>Phone #:<br>Alternate phone #: | Nearest relative not living with you:<br><br>Relationship to Patient:<br><br>Phone #:<br>Alternative Phone #: | Is your visit due to an injury? ☐Yes ☐No<br><br>Type of Injury:<br>☐Workers Comp Injury Date: _____<br>☐Auto Accident Injury Date: _____<br>☐Other Injury Date: _____ |

| INSURANCE - POLICY HOLDER INFORMATION | | |
|---|---|---|
| Name of Insured/Responsible Party: | Insured Social Security #: | Insured<br>Date of Birth: __ __/__ __ / __ __ __ __ |
| Home Address<br><br>City, State, Zip: | Phone #:<br><br>Work Phone #:<br><br>Alternate phone/cell #: | Employer Name & Address: |
| Insurance Company: | Insured ID#: | Relationship to Patient:<br><br>Do you have secondary insurance?<br>☐Yes ☐No |

*I have completed and reviewed the above information and to the best of my knowledge it is accurate. I authorize the individual physicians to advise me of any necessary procedures, diagnostic studies and treatment. I will notify you of any changes in my status of the above information*

Patient Signature: _____ Date: _____
Patient or Parental Signature (parental signature if patient is a minor)