



**Patient Information Update**

Name \_\_\_\_\_ Date \_\_\_\_\_  
(first) (middle) (last)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex  Male  Female Marital Status  S  M  W  D

Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone # \_\_\_\_\_ Alternate Phone # \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone# \_\_\_\_\_

Are you employed? Yes  No  Name of Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_  
(Please list any medicinal allergies including contrast dye, betadine, iodine and similar items)

Name of person(s) we may discuss your health information with: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_

What is the primary reason for your visit? \_\_\_\_\_

Is your visit the result of an accident?  Y  N If yes,  Work  Auto  Home Date of injury \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Address: \_\_\_\_\_

Have you previously been treated for this condition?  Y  N  
If yes, when and by whom \_\_\_\_\_

Were X-rays, MRI, or CT scans obtained?  Y  N If yes, where? \_\_\_\_\_

Do you have insurance?  Yes  No

Please give the receptionist your insurance card—we need an updated copy for your file. Thank you.

**Policies, Assignments, and Releases**

I, the undersigned, am requesting treatment by Dr. Phillip Hajek, Kristen Busby, PA-C, Dr. Davis Kinney, Dr. Daniel Webb, Suzanne Wilson, PT, and/or Teresa Bristol, PT, who are employees of Regional Health Group, Inc. I understand that while this is a multi-disciplinary practice offering orthopedic and chiropractic services as well as physical therapy, no doctor desires to disrupt any current doctor patient relationship I may have, and I am free to choose my own orthopedist, chiropractor, or physical therapist should any doctor here recommend such a referral. I further certify that I (or my dependent) have insurance with the company(s) or agency(s) provided, and I assign directly to Regional Health Group, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges whether or not they are paid by insurance. I hereby authorize my doctor(s) to release any information necessary to secure the payment of benefits or as needed to coordinate my care with other healthcare professionals. I authorize the use of this signature on all insurance claim submissions.

Signed \_\_\_\_\_ Date \_\_\_\_\_