THE BROADWAY CLINIC - PATIENT INFORMATION

TODAY'S DATE:_____ Your Social Security Number # ☐☐☐ ☐☐ ☐☐☐☐

FIRST NAME:_____ LAST NAME:_____ MI:_____ HEIGHT:_____ WEIGHT:_____

HOME ADDRESS:_____CITY:_____ STATE:_____ ZIP_____

HOME PHONE: ( ) _____CELL PHONE: ( )_____ DATE OF BIRTH:_____AGE _____

WHO REFERRED YOU? ☐ TV ☐ RADIO ☐ ATTORNEY ☐ SIGNAGE ☐ WEBSITE ☐ FACEBOOK ☐ TWITTER ☐ FRIEND/FAMILY/COWORKER

OTHER:_____MARITAL STATUS: ☐ SINGLE ☐ MARRIED SEX: ☐ MALE ☐ FEMALE

CURRENT EMPLOYMENT INFORMATION ☐ **Check here if unemployed**

EMPLOYER:_____

ADDRESS:_____CITY:_____

STATE:_____ZIP:_____OCCUPATION:_____

EMPLOYER PHONE: ( )_____

HEALTH INSURANCE INFORMATION -

Insurance Carrier/Network:_____

Name of Insured:_____ Relationship: _____

Insured's Employer:_____ GROUP NO./ID:_____

Insured's SSN# _____ - _____ - _____ Insured's DOB: ___/____/____

MEDICAL HISTORY

Past Family Medical History - Has any member of your family ever had any of the following: If yes, check box and write relationship to you.

☐ Arthritis _____ ☐ Cancer _____ ☐ Diabetes _____ ☐ Epilepsy _____ ☐ Gout _____
☐ Heart Disease _____ ☐ High Blood Pressure _____ ☐ Kidney Disease _____
☐Other:_____

YOUR Medical History – Do you have any of the following? Circle: NO if none or YES - if yes, please check the following that apply to YOU.

☐ Cancer ☐ Diabetes ☐ Epilepsy ☐ Gout ☐ Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐ Goiter ☐ Asthma ☐ Ulcers
☐ Emphysema ☐ Jaundice ☐ Frequent Kidney Infections ☐ Angina ☐ Tuberculosis ☐ Pneumonia ☐ Hepatitis ☐ Pancreatitis ☐HIV
☐ Cirrhosis ☐ Glaucoma ☐Other:_____

Past Social History

Do you smoke?_____ #packs per day?_____ #years?_____ Do you drink? YES NO How much and how often?_____
Do you take drugs OTHER than those prescribed to you by a physician (list):_____

Past Surgical History – Please list any surgical operations you have undergone and the year it was performed:

_____

Medication Allergies and Current Medications

Are you allergic to any type of medication? ☐ NO ☐☐*YES IF *YES, PLEASE SPECIFY: ☐ Sulfa ☐ Penicillin
☐ Other (Please List) _____
Are you taking any medication on a routine basis? ☐ No ☐ Yes – Please list:_____

_____

GYNECOLOGICAL HISTORY

When was you last menstrual period? _____ (mm/dd/yy) **Is there any possibility that you are pregnant now? Circle: YES NO**

SECTION A. IF YOU ARE HERE DUE TO AN ON-THE-JOB INJURY SKIP SECTION A AND GO TO SECTION B ON BACK.

YOUR auto insurance information:
Insurance Carrier:_____ Pol#:_____

Insured:_____Relationship:_____
If available, Insurance Agent Name and Phone Number:

_____

Attorney (if any):_____

OTHER Party's auto insurance information, if applicable:
Ins Carrier:_____ Pol#:_____

Claim#_____

Insured:_____ Driver Name:_____
If available, Insurance Agent Name and Phone Number

_____

Date of Accident:_____ **Approx. Time:**_____

I certify that to the best of my knowledge that the information listed above is complete, true and accurate.

PATIENT'S SIGNATURE:_____**DATE:**_____

SECTION B. ***WORKER'S COMPENSATION ONLY***

Name of employer at the time of injury:_____ Attorney:_____

Date of Injury:_____ If cumulative, date symptoms first began:_____ Date you first took off work due to this injury: _____

Job Title:_____ Job Description – What do you do at work? Please list. _____

_____

Describe how the accident occurred: _____

_____

_____

List all body parts injured and present complaints as related to THIS injury:

BODY PART	DESCRIBE INJURY	BODY PART	DESCRIBE INJURY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all doctors, hospitals, etc. and the date you visited each one in regards to the above injury:

Doctor:_____ From:_____ To:_____

Doctor:_____ From:_____ To:_____

Physical Therapy:_____From:_____ To:_____

Please check any procedures you have underwent and list the approximate date or month/year it was performed:

□ MRI _____ □ CT Scan _____ □ EMG _____ □ Bone Scan _____ □ Injections _____

□ Other:_____

Are you **currently** off work due to this injury? Circle one below and answer corresponding question.
YES if yes, since when? (approximate date)_____
NO if no, have you ever been off work due to this injury? NO YES if yes, from what date to what date _____ to _____

What is the name of the doctor who released you to return to work?_____

If applicable, what is the actual date you returned to work after the above stated injury?_____

Have you had previous WORK-RELATED injuries? Circle one: NO YES if yes, please list:

EMPLOYER	**BODY PART INJURED**	**APPROX. DATE OF INJURY**
_____	_____	_____
_____	_____	_____

Have you had previous injuries that are NON-WORK RELATED? Circle one: NO YES if yes, please list:

DESCRIBE HOW INJURY OCCURED	**BODY PART INJURED**	**APPROX. DATE OF INJURY**
_____	_____	_____
_____	_____	_____

What other types of jobs have you performed in the past and for approximately how long collectively?

JOB TYPE	**#YEARS/MONTHS**	**JOB TYPE**	**#YEARS/MONTHS**
_____	_____	_____	_____
_____	_____	_____	_____

What is the highest educational level you have completed? (i.e. 10th gd, GED or Bachelor's Degree)
_____

I certify that to the best of my knowledge that the information listed above is complete, true and accurate.

PATIENT'S SIGNATURE:_____**DATE:**_____