Welcome to Dr. Ibolit

PATIENT INFORMATION

First Name:_____

Last Name:_____ **Middle Initial**: _____

Address:_____

City:_____ **State**:_____ **Zip Code**:_____

Home Phone: (____)_____

Cell Phone: (____)_____

Email:_____

Sex: ☐ M ☐ F **Birth Date**: _____

☐ Single ☐ Married ☐ Separated

☐ Divorced ☐ Widowed ☐ Minor

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: (____)_____

How did you hear about us?

_____

WORKER'S COMP. INFORMATION

Employer: _____

Address: _____

Phone: (___) ___ - _____

Have injuries been reported? ☐ Yes ☐ No

Insurance Carrier/MCO: _____

Claim # _____

Case Manager: _____ Phone: (___) ___ - _____

ASSIGNMENT AND RELEASE

I understand that I am financially responsible for all charges whether or not paid by my insurance. If I provide insurance, I authorize the use of my signature on all insurance submissions.

I certify that I, and/or my dependent(s), have insurance coverage with with the above named insurance, and assign directly to the Dr. Ibolit Manual Medicine Clinic all insurance benefits, if any, otherwise payable to me for services rendered.

The above-named clinic may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

_____

PrintName

_____

Signature

_____

Date

INJURY INFORMATION

Date of Injury: _____ / _____ / _____

Attorney (if applicable): _____ Phone: (____)_____

Treating Physician (if applicable): _____ Phone: (____)_____

Primary Care Physician (if applicable): _____ Phone: (____)_____

Were you injured as a result of a car accident while at work? ☐ Yes ☐ No

Briefly describe what happened during your injury:

_____

_____

Are you continuing to work? ☐ Yes ☐ No

If yes, why? ☐ I can tolerate the pain ☐ I will lose my job if I don't work ☐ I have to provide for my family

☐ Other: _____

If no, are you seeking to get a light duty or work release note? ☐ Yes ☐ No

HEALTH HISTORY

Previous Surgeries: ☐ None ☐ Yes: _____ Year: _____

_____ Year: _____

Medications: ☐ None ☐ Yes: _____

Are you experiencing any unexplained: ☐ Malaise ☐ Weight Loss ☐ Energy Loss ☐ Weakness

Previous Injuries: ☐ None ☐ Neck ☐ Back ☐ Knee ☐ Leg/Ankle/Foot ☐ Elbow/Hand

Are you pregnant: ☐ No ☐ Yes **Due Date:** _____

Who have you seen for this injury/episode? ☐ N/A ☐ Yes: _____

What diagnostics have you received for this injury/episode?(Check all that apply)

☐ None ☐ CT Scan ☐ MRI ☐ X-Rays ☐ Other: _____

Have you ever had any of the following?(Check all that apply)

☐ Allergies	☐ Anemia	☐ Arthritis/Swollen Joints
☐ Asthma, Bronchitis, or Emphysema	☐ Blood Clot	☐ Bowel or Bladder Problems
☐ Breast Implants	☐ Cancer/Chemo	☐ Chest Pain
☐ Diabetes	☐ Difficulty Sleeping	☐ Dizziness or Fainting
☐ Emotional/Psychological Problems	☐ Epilepsy/Seizures	☐ Gout
☐ Heart Attack	☐ Heart Condition	☐ Hernia
☐ High Blood Pressure	☐ Infectious Diseases	☐ Joint Replacement
☐ Metal Implants	☐ Numbness or Tingling	☐ Osteoporosis
☐ Pacemaker	☐ Rheumatoid Arthritis	☐ Skin Conditions
☐ Severe or Frequent Headaches	☐ Shortness of Breath	☐ Stroke
☐ Thyroid Trouble/Goiter	☐ Varicose Veins	☐ Vision or Hearing Difficulties

☐ Other: _____

WORK ACTIVITY

Occupation: _____

☐ Sitting ☐ Standing

☐ Light Labor ☐ Heavy Labor

HABITS

☐ Smoking Packs/Day:_____

☐ Alcohol Drinks/Week:_____

☐ Coffee/Caffeine Drinks Cups/Day:_____

☐ High Stress Level Reason:_____

Please list any additional information that would assist us in providing care to you:

_____

_____

_____

_____

_____

Dr. Ibolit

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