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8 Nas Welcon	nao		July 1
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Retitent future			
Date	۲۵۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰۰	Who is responsible for this account?	
SS/HIC/Patient ID #		Relationship to Patient	
Patient Name		Insurance Co.	
First Name	Middle Initial	Group #	—
Address	4-1462/	Is patient covered by additional insurance? Yes No	
City	40 40 H	Subscriber's Name	
State Zip		Birthdate SS#	
E-mail		Relationship to Patient	
Sex 🗆 M 🔤 F Age	—	Insurance Co Group #	
Birthdate	—	ASSIGNMENT AND RELEASE	
🗆 Married 📄 Widowed 📄 Single	Minor	I certify that I, and/or my dependent(s), have insurance coverage	
Separated Divorced Partnered	d for years	Name of Insurance Company(ies) and assign direct	y to
Occupation		Dr all insurance ben if any, otherwise payable to me for services rendered. I understand that	efits,
Patient Employer/School		financially responsible for all charges whether or not paid by insurance authorize the use of my signature on all insurance submissions.	
Employer/School Address		The above-named doctor may use my health care information and may disc	close
		such information to the above-named Insurance Company(ies) and their ag for the purpose of obtaining payment for services and determining insura	gents
Employer/School Phone ()		benefits or the benefits payable for related services. This consent will end w my current treatment plan is completed or one year from the date signed be	
Spouse's Name	1		
Birthdate	and the second se	Signature of Patient, Parent, Guardian or Personal Representative	
SS#	to Aug	Please print name of Patient, Parent, Guardian or Personal Representativ	ve
Spouse's Employer			
Whom may we thank for referring you?		Date Relationship to Patient	100-100-000-0.00-
Phone Numbers		Accident Information	
Home Phone ()		Is condition due to an accident? 🗌 Yes 🗌 No	
Cell Phone ()		Date	
Best time and place to reach you IN CASE OF EMERGENCY, CONTACT		Type of accident Auto Work Home Other	romb, or rado Pridewaw
Name		To whom have you made a report of your accident?	intra sector in a de la sector
Relationship		Attorney Name (if applicable)	Sector States and Powers
Home Phone ()			all work of the law to
Work Phone ()			The book state of the log
	- Patient	Condition	
Reason for Visit			
When did your symptoms appear?			
Is this condition getting progressively wors Mark an X on the picture where you continue			
Rate the severity of your pain on a scale from 1 (I			
Type of pain:	□ Throbbing □ Nun □ Cramps □ Stiff	nbness Aching Shooting ness Swelling Other	
How often do you have this pain?		(
Is it constant or does it come and go?			1000 C
Does it interfere with your Work Sleep Activities or movements that are painful to pe	Celler.	Recreation Recreation Malking Bending Lying Down	
(Vers.(5255564)	enterent en ergen angelen an	V E R – #20591 – © 2004 Medical Arts Press [®] 1-800-328	8-2179

						HISTORY 1					
What treatmer	-		eived for your condit				. ,	al Therap			
				-		on					
Date of Last:											
a nede su provinsi de la contra											
Instance di vuore	Dental X-Ra	ay		MRI, CT	-Scan, Bo	one Scan					
Place a mark o	on "Yes" or "I	No" to indic	ate if you have had	any of the	e followin	g:					
AIDS/HIV	□ Yes	s 🗌 No	Chicken Pox	🗌 Yes	🗌 No	Liver Disease	🗌 Yes	🗌 No	Rheumatoid Arthritis	s 🗌 Yes	🗌 No
Alcoholism	□ Yes	No 🗌 No	Diabetes	🗌 Yes	🗌 No	Measles	🗌 Yes	🗌 No	Rheumatic Fever	🗌 Yes	🗌 No
Allergy Shots	🗌 Yes		Emphysema] Yes		Migraine Headaches		🗌 No	Scarlet Fever	☐ Yes	□ No
Anemia	Yes	_	Epilepsy	☐ Yes		Miscarriage	☐ Yes	□ No	Stroke	☐ Yes	🗌 No
Anorexia			Fractures	☐ Yes		Mononucleosis	Yes	□ No	Suicide Attempt	☐ Yes	
Appendicitis	∐ Yes		Glaucoma			Multiple Sclerosis		□ No	Thyroid Problems		
Arthritis			Goiter	☐ Yes □ Yes		Mumps	☐ Yes	🗌 No	Tonsillitis		
Asthma Blooding Disor	⊡ Yes rders ⊡ Yes		Gonorrhea Gout			Osteoporosis Pacemaker	☐ Yes ☐ Yes		Tuberculosis Tumors, Growths	☐ Yes ☐ Yes	□ No □ No
Bleeding Disor Breast Lump	ruers ⊡ res		Heart Disease		∐ No □ No	Parkinson's Disease			Typhoid Fever	⊡ Yes	
Bronchitis			Hepatitis	☐ Yes		Pinched Nerve	∏ Yes		Ulcers	☐ Yes	
Bulimia	☐ Yes		Hernia	☐ Yes		Pneumonia	☐ Yes		Vaginal Infections	⊡ Yes	
Cancer	□ Yes		Herniated Disk	∏ Yes	_	Polio	☐ Yes	No	Venereal Disease	☐ Yes	No
Cataracts	<u> </u>	□ No	Herpes	□ Yes		Prostate Problem	□ Yes	 □ No	Whooping Cough	 Yes	□ No
Chemical			High Cholesterol	 □ Yes	□ No	Prosthesis	 □ Yes	□ No	Other		
Dependency	🗌 Yes	🗌 No	Kidney Disease	🗌 Yes	🗌 No	Psychiatric Care	🗌 Yes	🗌 No			
Reconservation of the program was a served of the second server of the s	enverservente montatio anota, « v inventa	and the device provide and an inclusion	99 - 62 March 1994 (1997) (1	non nya amin'ny fanisana amin'ny fanisa	1986-1986 (2019) (2019) (48-446)	na na kato kato kato kato kato kato kato kat	Landon (Martin Data) - A Anna	na antar dhasa dhasa aha sa ar na n	nan an		MNY/2000 Constantion
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M.Lara	None		□ Sitting		er-can engen w	Smoking		Pa	cks/Day		
	🗌 Moder	rate	□ Standing		in strange of a finite set	Alcohol		Dr	inks/Week		
	📄 🗌 Daily		Light Labor		and and and an	Coffee/Caffeine	Drinks	Cı	ips/Day		
	🔄 🗌 Heavy	1	Heavy Labor			 ☐ High Stress Lev			ason		
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Injuries/Surger	ies you have	had		Descri	iption				Date		
Falls											
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