Align Clinic, LLC
PATIENT INFORMATION FORM

Section 1 – Patient Information

Patient Name:__________________________ ________ __________________________ Date of Birth:________________

First MI Last

Home Address:________________________________ City:_________________ State:______ Zip Code:____________

Home Phone:______________________ Work Phone:____________________ Mobile Phone:___________________

E-mail Address:____

Sex: ☐ Male ☐ Female Height:_________ Weight:_________ Marital Status:______________ SSN:____________

Emergency Contact Name:____ Phone:______________________

How did you hear about us?____

Section 2 – Parent / Guardian / Financially Responsible Party

Name:_____________________________________ Date of Birth:________________ SSN:______________________

Relationship to Patient:_____________________________ Phone (If different from above):________________________

Section 3 – Medical Information

Diagnosis:____ Date of Injury:___________________

Was the injury work-related? Yes / No If yes, Employer at time of accident:____________________________________

Workers Comp Company:______________________________________

Claim#:____

Adjustor Name:____________________ Phone:___________________

Referring Physician:____ Phone:______________________________

Primary Care Physician:____ Phone:______________________________

Are you diabetic? Yes / No If yes, Name of physician treating your diabetes:_______________________________

Phone:______________________________

If amputee, Amputation Date:____________Type of Amputation:_____________Amputation Side: ☐ R ☐ L ☐ Bilateral

I certify that the information provided above is accurate and complete.

____ ____________________________________

Signature of Patient/Responsible Party Date