New Patient Intake Form

Accident & Injury Center, Dr. Wade Burbank, 6403 NE 117th Ave Suite 109, Vancouver WA 98662, (360) 567-1739

Date _____

Name_____ Address_____

SS #_____ City_____ State_____ Zip Code_____

E-Mail _____ Referred By_____

Cell Phone _____ Home Phone _____ Work Phone _____

Age_____ Birth Date_____ Marital: M S W D How many Children? _____

Occupation (if dependent list parent's occupation)_____

Employer_____ Address _____

Name of Spouse _____ Occupation _____

Employer _____ Office Phone _____ Other Phone _____

Emergency Contact _____Phone _____ Other Phone _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT! 0 Cash 0 Check 0 Visa/MasterCard

Person responsible for payment

Name_____ Phone _____ Other _____

Address_____ City _____ Zip _____

Are you insured? 0 YES 0 NO Insurance Company _____

Other Doctors seen for this Condition_____

Have you been treated for any health condition by a physician in the last year? 0 YES 0 NO

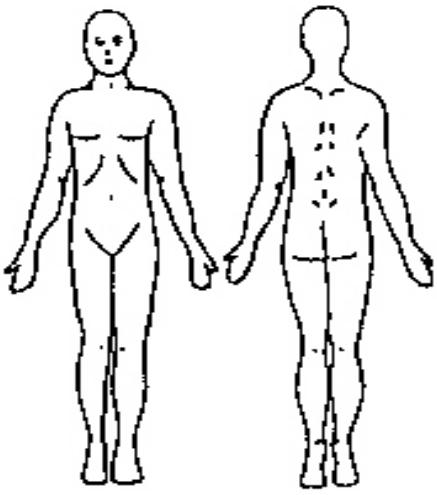
Describe_____

_____

Current Medications_____

_____

Do you smoke? 0 YES 0 NO



Confidential Health History

Please outline on the diagram the area of your Pain/Discomfort.

Please describe your present complaint

_____

_____

_____

Frequency of complaint (circle one) Constant-100% Frequent-75% Intermittent-50% Occasional-25%

Intensity of Complaint (circle one) Minimal Mild Moderate Significant Severe

What aggravates the problem? What have you tried for relief? _____

_____

Is this a work related injury? 0 YES 0 NO , L&I Claim # _____Work Injury Date_____

When did your present complaints occur? _____

Who has treated you for this condition (if anyone)? _____

Is this condition interfering with your 0 Work 0 Sleep 0 Recreation Dates missed: _____

Have you had this condition or similar conditions in the past? 0 YES 0 NO If so, when? _____

What treatment did you receive/medication? _____

If any of the following have happened to you, give approximate dates & briefly describe injury:

Auto/Motorcycle accidents: _____

Falls or other injuries: _____ Spinal or neck injuries: _____

Broken bones: _____ Knocked unconscious: _____

Surgeries: _____ Health problems of parents: _____

Please check any of the following that apply to your current/past medical history:

- o Allergy
- o Asthma
- o Shoulder pain
- o Heartburn
- o Hay fever
- o Hiatal hernia
- o Migraines
- o Sore throats
- o Loss of weight
- o Shortness of breath
- o Hardening of arteries
- o Liver trouble
- o Hyperactivity
- o Numbness in legs or feet
- o Stroke
- o Swollen ankles
- o Stomach ulcers
- o Foot trouble
- o Frequent urination
- o Kidney stone
- o Kidney infection
- o Bladder infection
- o Painful urination
- o Poor urine control
- o Blood in urine
- o Prostate trouble
- o Swollen joints
- o Belching or gas
- o Fainting
- o Colon trouble
- o Headaches
- o Nosebleeds
- o Tuberculosis
- o Difficulty breathing
- o Jaundice
- o Polio
- o Bursitis
- o Poor circulation
- o Sprained ankle
- o Vomiting of blood
- o Bed-wetting
- o Low backache
- o Painful tailbone
- o Sciatica
- o Spinal curvature
- o Stiff or painful neck
- o Leg pain
- o Pain between shoulders
- o Arm Pain
- o Knee Pain
- o Thyroid trouble
- o Diabetes
- o Enlarged Glands
- o Gout
- o Nasal congestion
- o Itching
- o Chronic cough
- o Heart disease
- o Hemorrhoids
- o Cancer
- o Arthritis
- o Chest pain
- o Vomiting
- o Broken bones
- o Weakness in legs
- o Rheumatic fever
- o Sinus infection
- o Convulsions
- o Stomach aches
- o Dentures
- o Bruise easily
- o Diarrhea
- o Varicose veins
- o Gall bladder trouble
- o Depression
- o Emphysema
- o Low blood pressure
- o Poor appetite
- o Surgery
- o Weakness in arms
- o Slow heart beat
- o Bad posture
- o Anemia
- o Poor hearing
- o Burning sensations
- o Fatigue
- o Eczema/Hives
- o Constipation
- o Loss of sleep
- o Excessive hunger
- o Nervousness
- o Spitting up blood
- o High blood pressure
- o Nausea
- o Tumor
- o Numbness in arms/hands
- o Rapid heart beat
- o Difficulty swallowing
- o Heart attack
- o Ringing in ears
- o Angina

For Women Only:

- o Premenstrual tension
- o Menopausal symptoms
- o Excessive flow
- o Tubal ligation
- o Vaginal discharge
- o Unable to get pregnant
- o Menstrual cramps
- o Hysterectomy
- o Lumps in breast
- o Irregular cycle

Is there a possibility that you may be pregnant? 0 YES 0 NO

Date of last menstrual period _____

If this problem went without being taken care of, how do you think it would affect you? _____

_____

Any questions or concerns? _____

_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Accident & Injury Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Accident & Injury Walk In Center will be to my account on the receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I also permit the Accident & Injury Center to file any insurance related complaint on my behalf to the Insurance Commissioner if needed.

I understand that treatment results are not guaranteed. I have also had an opportunity to ask questions about treatment options, risks and benefits and I wish to rely on the physician to exercise judgment during the course of the procedure/treatments which the physician feels are in my best interest, at the time, based upon the facts then known.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____