Returning Patient Health History Update

This is a condensed form for your convenience. Please fill in ALL information even if nothing has changed since your last visit.

Name: _____

Address: _____City:_____ St:_____ Zip:_____

Home Phone: _____Cell: _____Work:_____

Email Address: _____

Date of Birth: _____

Are you Pregnant? _____

Health Information:

Are you suffering a new symptom since your last visit or is this a reoccurrence of an old symptom?

_____

What is the problem you are experiencing? _____

Was there an accident that resulted in this pain? _____

What makes it worse? _____Better? _____

Are you on any new medications since your last visit? _____

What medications are you currently on? _____

Have you had any other traumas or accidents since your last visit (car accidents, falls, etc)? If so, what?

_____

I, the undersigned, hereby authorize the staff to perform such services as deemed necessary by Dr. Jessica Scherer. Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims by provider or agent. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____