

*Wind Touch Healing, L.L.C. - Patient Confidential Information*

1. Name \_\_\_\_\_  
First Middle Last

2. Address \_\_\_\_\_  
Street City State Zip

3. Home Phone \_\_\_\_\_ 4. Business Phone \_\_\_\_\_

5. Fax \_\_\_\_\_ 6. Email \_\_\_\_\_

7. Age \_\_\_\_\_ 8. Date of Birth \_\_\_\_\_ 9. Sex \_\_\_\_\_ 10. Marital: M S D W

11. Social Security No \_\_\_\_\_ 12. Driver's License No \_\_\_\_\_

13. Occupation \_\_\_\_\_ 14. Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City St. Zip

15. Bank \_\_\_\_\_  
Name Address Account No.

**CASE HISTORY**

16. Chief Complaint \_\_\_\_\_

17. Complaint result of:  Auto Accident  Injury  Job Related  Other

18. Date of accident/Injury/Other \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

19. Have you seen any other doctor about this condition? \_\_\_\_\_ If yes, when? \_\_\_\_\_  
Doctor's Name \_\_\_\_\_ Address \_\_\_\_\_

20. Have you had recent X-Rays? \_\_\_\_\_ If yes, when? \_\_\_\_\_ Area X-Rayed \_\_\_\_\_

21. Spouse's name \_\_\_\_\_ Spouse's SSN \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

22. Nearest relative not living with you \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip Phone \_\_\_\_\_

23. In case of emergency, call \_\_\_\_\_  
Name Street City Phone

FOR FEMALES: Are you pregnant? \_\_\_\_\_ IF YES, HOW LONG? \_\_\_\_\_

FOR MINORS: List both parents' names and addresses \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FINANCIAL ARRANGEMENTS**

How do you plan to handle your account? (Check one)  Cash  Check  Master Card  Visa

**INSURANCE INFORMATION**

Do you have a personal, group health or accident insurance? \_\_\_\_\_ If yes, give: \_\_\_\_\_  
Company Name \_\_\_\_\_ Address \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Group Number \_\_\_\_\_

I have read the above information and certify it to be true and correct to the best of my knowledge and belief and hereby authorize this office to do whatever is necessary, in accordance with state statutes, for the care and management of this complaint.

DATED \_\_\_\_\_ PATIENT'S SIGNATURE \_\_\_\_\_  
(parent's signature if patient is minor)

Referred by \_\_\_\_\_

