

First Health Associates—Confidential Health Information Questionnaire

This information is needed to better serve you. Please fill-in all portions of the form. If you need assistance, please ask our Front Desk Staff and they will be glad to assist you.

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

E-Mail _____

Home Phone _____ Cell _____ Work _____

Date of Birth _____ Age _____ Marital Status: M S D W

Employment Status: F/T P/T Retired Not Employed Student

Employer Name: _____ Occupation _____

How were you referred to First Health Associates?

Friend: _____ Internet: (site) _____

News Paper: _____ Provider: _____

Other: (please be specific) _____

Is your visit today the result of an accident? Y or N

Health Insurance Company Name: _____

Name of person to contact in event of an emergency _____

Relationship to you _____ Contact Number _____

Do You have a Primary Care Doctor? Y N

Name _____ Phone _____

Address _____ City _____

I attest that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement or settlement.

Patients Name _____ Date _____

Patient's Signature _____

Guardian's Signature, Name & Relationship _____