DX Medical & Physical Therapy Clinic, Ltd.

7601 W. Montrose Ave. • Norridge, IL 60706 708-452-5500

PATIENT INFORMATION

Please check where/how accident or injury happened:

Home _____ Workplace _____ Auto accident _____ Other_____

NAME ____

ADDRESS _______________________ CITY _________________ STATE ______ ZIP __________

HOME PHONE NUMBER ________________________ CELL PHONE ________________________

AGE ___________ BIRTHDATE _______________ SOCIAL SECURITY #_____________________

EMPLOYER'S NAME ________________________ OCCUPATION ___________________________

WORK ADDRESS ____

BUSINESS PHONE _________________________ SUPERVISOR ____________________________

What is your major complaint? ____

How long have you had this condition? ___________________ x-rays taken? Yes/No _____________

Are you on any medication? ____

Please describe how the accident or injury happened? _________________________________

____

____ Date of accident __________________

Were you taken to hospital? _________________ Where _____________________________________

Did you obtain an attorney? __________________ Name ______________________________________

Address ______________________ Suite ________ City _____________ State______ Zip ___________

Phone number ____

PLEASE CHECK BELOW HOW YOU WILL BE PAYING FOR YOUR VISITS:

Health Insurance _____ Personal check _____ Cash_____ Credit card_____ Other (please explain) _____

I clearly understand and agree that all the above information is correct to the best of my knowledge. I also understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. That also allows the Doctor to receive assignments of benefits directly to the office.

Patient's signature ____ Date ______________________

“ b r i n g i n g b a c k h e a l t h c a r e ”