Align Clinic, LLC
PATIENT INFORMATION FORM

Section 1 – Patient Information

Patient Name: _____ _____ _____ Date of Birth: _____
First MI Last

Home Address: _____ Apt# _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

E-mail Address: _____ Ethnicity: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ Marital Status: _____ SSN: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about us? _____

Section 2 – Parent / Guardian / Financially Responsible Party / Primary Insurance Subscriber

Name: _____ Date of Birth: _____ SSN: _____

Relationship to Patient: _____ Phone (If different from above): _____

Employer: _____

Section 3 – Medical Information

Diagnosis: _____ Date of Injury: _____

Was the injury work-related? Yes ☐ / No ☐ If yes, Employer at time of accident: _____

Workers Comp Company: _____

Claim#: _____

Adjustor Name: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Are you diabetic? Yes ☐ / No ☐ If yes, Name of physician treating your diabetes: _____

Phone: _____

If amputee, Amputation Date: _____ Type of Amputation: _____ Amputation Side: ☐ R ☐ L ☐ Bilateral

I certify that the information provided above is accurate and complete.

_____ _____
Signature of Patient/Responsible Party Date