MICHIANA WELLNESS & LONGEVITY CLINIC

PTN#

PATIENT DATA QUESTIONNAIRE DATE_____/_____/_____

Patient Name____
(FIRST) (MI) (LAST)

Address____
(STREET) (APT#)

____
(CITY) (STATE) (ZIP)

Home Phone (____)_____-_________ Work Phone (____)_____-_________ Cell Phone (____)_____-_________

Email address: ____________________ Date of Birth______/______/_________ Age ________ Sex_________

How would you like to be contacted for appointments (Circle One): Text to Cell Phone, Email, Phone Call

SS#______-______-______ Your Driver's License Number & State ___________________________________

Marital Status (circle one): Married Divorced Single Widowed Weight:________ Height:_________

Spouse's Name ____
(FIRST) (MI) (LAST)

Your Occupation__________________________ School/Employer_________________________________

Work Address____
(STREET) (CITY) (STATE) (ZIP)

Closest Relative NOT Living With You____
(Relationship to you)

Relative's Address/Phone____ (____)____-__________
(STREET) (CITY) (STATE) (ZIP) (PHONE)

Condition is Due to: Auto Accident, Work, Other Accident, Unknown Cause, Illness

Date of Accident ______/______/______ Ever had these symptoms before? Y/N When? ______/______/______

Name of Your Insurance Co.____

Phone # of Insurance Co (____)_____-_________Contact Person________________________________

Your Insurance Co. Claims Address____
(STREET or PO BOX)

____
(CITY) (STATE) (ZIP)

Policy No.________________________________ Claim No. or Group No.__________________________

Policy Renewal Date ___/____/____ If applicable, Amount of Deductible $______________ Coverage %__________

The following information refers to the person who's insurance you will be using (spouse or self, etc.). This is NOT the person who hit you. Please fill out all information completely.

Insured's Name____
(FIRST) (MI) (LAST)

Insured's Address____
(STREET) (APT#)

____
(CITY) (STATE) (ZIP)

Your Relationship to the Insured (circle one): self spouse child other Insured's Sex: male female

Insured's Soc. Sec. No. ______-________-_________ Insured Date of Birth ______/______/______ Next Page ➔

The following information refers to the insurance of the "At Fault" person (who hit you), unless you were at fault. Please fill out all information completely, if possible and if applicable.

Name of Liability Insurance Co.____

Phone # of Insurance Co (_____)______-_________Contact Person______________________

Insurance Co. Address____
(STREET or PO BOX)

____
(CITY) (STATE) (ZIP)

Claim Number ______________________________ Policy No.______________________________

Insured's Name____
(FIRST) (MI) (LAST)

Insured's Address____
(STREET) (APT#)

____
(CITY) (STATE) (ZIP)

Insured's Date of Birth ______/______/_________ Insured's Sex (circle one) male female

IF YOUR CASE INVOLVES AN AUTO ACCIDENT PLEASE ANSWER THE FOLLOWING QUESTIONS. IF A QUESTION DOESN'T APPLY TO YOU , LEAVE IT BLANK.

Your Attorney's Name & Firm Name____

Attorney's Address____
(STREET) (CITY) (STATE) (ZIP)

Attorney's Phone No. (______)_______-___________

Time of Accident___________A.M./ P.M. Location of Accident______________________________

City___________________ To Whom Was the Accident Reported (Ins. Co., Police)___________________

Was an Accident Report Filed? Yes No Was a Police Report Made? Yes No

To Whom was the Citation/Ticket Given (If Any) ______________________________________

You Were: ( )Driver ( )Passenger ( )Front Seat ( )Rear Seat ( )Pedestrian ( )Bicyclist

Number of People In Vehicle______________ Were YouWearing Seat Belts? Yes No

In Which Direction Were You Headed ( )North ( )South ( )East ( )West
On Which Street____

In Which Direction Was the Other Car Headed ( )North ( )South ( )East ( )West
On Which Street____

You Were Struck From ( )Behind ( )Front ( )Left Side ( )Right Side

Were You Knocked Unconscious? Yes No Any Loss of Memory? Yes No

In Your Own Words Describe the Accident (include what happened to you in the car):

____

____

____

____

____

____

SIGNATURE DATE Next Page ➔

Your Health or Other Insurance Information:
(If Applicable)

Name of Insurance Co.____

Phone # of Insurance Co (____)_____-_________Contact Person____________________________________

Insurance Co. Address____
(STREET or PO BOX)

____
(CITY) (STATE) (ZIP)

ID or Claim Number ___________________________________ Policy No.__________________________________

Insured's Name____
(FIRST) (MI) (LAST)

Insured's Address____
(STREET) (APT#)

____
(CITY) (STATE) (ZIP) **(over)**

Insured's Soc. Sec. No. _________-________-_________ Insured Date of Birth ______/______/______

Insured's Sex (circle one) male female

Please let us make a copy of your insurance cards and/or your insurance endorsements page (contains your MedPay amount).

We also will need a copy of your Accident Report from the police department in the district where your accident occurred.

Any Other Information you think we should know: