



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 ____

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. 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 Soc. Sec. No. ____-____-____ Insured Date of Birth ____/____/____

Insured's Sex (circle one) male / female

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 applicable.

Name of Liability Insurance Co. _____

Phone # of Insurance Co (_____) _____ - _____ Contact Person _____

Insurance Co. Address _____
(STREET or PO BOX)

Claim Number _____ (CITY) _____ (STATE) _____ (ZIP) _____
Policy No. _____

Insured's Name _____
(FIRST) _____ (MI) _____ (LAST) _____

Insured's Address _____
(STREET) _____ (APT#) _____

Insured's Soc. Sec. No.? _____ - _____ - _____ Insured's Date of Birth ____/____/____ Sex (circle): 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. (_____) _____ - _____ Email/FAX _____

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 _____ Wearing Seat Belts? Yes/ No, Adjustable Headrests? 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 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.