

Liberty Healthcare Confidential Patient Case History

4301 Saturn Rd. #201 Garland, TX, 75041

This confidential history will be part of your permanent records.

First Name _____ **Middle** _____ **Last** _____

Date of Birth ____ / ____ / ____ **Age** _____ **SSN** _____ - _____ - _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Gender Male Female **Marital Status** Single Married

Race White Black/African American Hispanic Other _____

Language English Spanish Other _____

Home Phone _____ **Cell Phone** _____

Are we able to leave a detail message on your phone lines? Yes / No

Email Address _____ @ _____ . _____

Are we able to email you? (No medical information will be released through email) Yes / No

Emergency Contact _____ **Relationship to you** _____

Phone Number _____

Employment Status Employed Student Retired N/A

Employer _____ **Work Number** _____

Occupation _____ **City** _____

Date of accident? ____ / ____ / ____ **Where did accident occur? City:** _____ **State:** _____

Describe the accident in your own words:

Did the ambulance EMT's examine you at the scene of the accident? Yes / No

Did you go to the Hospital? No / Yes, **Name of Hospital** _____

Allergies: 1. _____ **2.** _____ **3.** _____ **4.** _____ **If none, check here**

Current Medication: 1. _____ **2.** _____ **3.** _____ **4.** _____ **If none, check here**

List Surgical Operation: _____

Family History: Father Illnesses/Diseases _____

Mother Illnesses/Diseases _____

Medical History: Please check ALL that apply to you.

- Muscle Pain
- Muscle Weakness
- Muscle Cramps
- Muscle Twitching
- Joint Stiffness
- Joint Pain
- Seizures
- Vertigo/Dizziness
- Hand Trembling
- Loss of Sensation
- Poor Coordination
- Weak Hand Grip
- Difficulty Speaking
- Loss of Memory
- Migraines
- Mental Illness
- High Blood Pressure
- Angina/ Chest Pain
- Heart Trouble
- Stroke
- Cancer
- Depression/Anxiety
- Arthritis
- Kidney Stones
- Diabetes
- Bladder Trouble
- Bowel Trouble

Social History:

- Caffeine Use Heavy Moderate Light N/A
- Alcohol Use Heavy Moderate Light N/A
- Smoke Use Heavy Moderate Light N/A
- Work/Job Heavy Moderate Light N/A
- Mental Work Heavy Moderate Light N/A
- Exercise Heavy Moderate Light N/A

We use an open Therapy area. If at any time you desire privacy for therapy or private consultation please notify staff.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the Insurance Company and that any amount authorized credited to my account upon receipt. I permit this office to endorse to issue remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Liberty Healthcare extends credit to me and I also understand that if I suspend or terminate my care of treatment, any fees for professional services rendered to me will be immediately due and payable, unless prior arrangements are made. I hereby authorize the doctors at Liberty Healthcare and whomever they may designate as their assistant to administer treatment as they so deem necessary and also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is correct. I authorize and assign the direct payment by an insurance company obligated to make payment based on the charges made for your service.

Patient or Guardian's Signature _____ **Date** _____