THE CENTER FOR MANUAL MEDICINE
&
REGENERATIVE ORTHOPEDICS

"We help you, help yourself"

5000 SW 21st Street Topeka, KS 66604 Phone: 785-271-8100 Fax: 785-271-9257 ctrmm.com

CONFIDENTIAL PATIENT CASE HISTORY

Full Name: _____Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Race: _____ Age: _____ Sex: _____ Marital Status: M__ S__ W__ D__

Home Phone: _____ Cell Phone: _____ Work Number: _____

Email: _____

Contact for our Appointment Reminders? Call ____ Text _____ Preferred Contact Number: _____

Employer: _____ Occupation: _____ ___

Spouse/Significant Other:

Name: _____Employer: _____ Work Phone: _____Cell Phone: _____

Insurance: _____

Cardholders Name: _____Card holders DOB: _____

Emergency Contacts:

1) Name: _____ Relationship to you: _____ Phone #: _____

2) Name: _____ Relationship to you: _____ Phone #: _____

General Information:

How did you hear about us? _____ Were you referred? YES NO By whom? _____

Hospital Preference: _____

Do your give us permission to discuss your records with someone else? YES NO

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Is your condition due to an active Motor Vehicle Accident (MVA), Worker's Compensation (WC), or Personal Injury Claim? YES NO

If yes please explain:

_____

_____

I UNDERSTAND & AGREE THAT HEALTH & ACCIDENT POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER & MYSELF. FUTHERMORE, I UNDERSTAND THAT THE CENTER FOR MANUAL MEDICINE & REGENERATIVE ORTHOPEDICS WILL PREPARE ANY NECESSARY REPORTS & FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THIS OFFICE WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. HOWEVER, I UNDERSTAND & AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME & THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT SHOULD MY INSURANCE NOT COVER MY TREATMENT.

Signature: _____ Date: _____