
PATIENT INFORMATION

PATIENT NAME _____ SEX _____ BIRTHDATE _____ AGE _____
SSN _____ PHONE _____ ALT PHONE _____
ADDRESS _____ CITY & ZIP _____

PLEASE ANSWER THE FOLLOWING (IF PATIENT IS A MINOR, PROVIDE PARENT'S INFORMATION BELOW)

IF PATIENT IS A MINOR, NAME OF PARENT _____
YOUR EMPLOYER _____ OCCUPATION _____
EMPLOYER ADDRESS _____ CITY & ZIP _____
EMPLOYER PHONE _____
IF MARRIED, NAME OF SPOUSE _____
SPOUSE'S EMPLOYER _____
NAME OF EMERGENCY CONTACT _____ RELATIONSHIP _____
CONTACT PHONE _____
WHO REFERRED YOU TO DR. BARNES _____
WHO IS YOUR FAMILY DOCTOR _____ PHONE _____
IS AN ATTORNEY REPRESENTING YOU FOR THIS INJURY? __YES __NO
IF YES, ATTORNEY NAME _____ PHONE NUMBER _____
WERE YOU INJURED ON THE JOB __YES __NO

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURANCE CO _____
NAME OF POLICYHOLDER _____
POLICYHOLDER DATE OF BIRTH _____
ID / POLICY NUMBER _____
GROUP NUMBERS _____

SECONDARY INSURANCE

NAME OF INSURANCE CO _____
NAME OF POLICYHOLDER _____
POLICYHOLDER DATE OF BIRTH _____
ID / POLICY NUMBER _____
GROUP NUMBERS _____

AUTHORIZATION

I hereby authorize Frank L. Barnes, M.D. and/or J. Peyton Barnes, M.D. to release any medical information acquired in the course of my examination or treatment to my insurance company, and permit payment directly to my physician for the unpaid balance for professional services rendered. A photocopy will be considered as binding as the original signature. I understand that this authorization does not release me from any personal responsibility for payment of all charges within 30 days.

Signed _____ Date _____

Frank L. Barnes, M.D., P.A.
J. Peyton Barnes, M.D.

4126 SWFWY #1410 Houston, TX 77027
DATE _____

MEDICAL INFORMATION

FRANK L. BARNES, M.D., P.A.

What part(s) of your body are bothering you? _____

When did it start? _____ Was it due to an accident? _____

How did it begin? _____

What makes the pain worse? _____

What eases the pain? _____

Is your pain: Continuous _____ Off and On _____ Sharp _____ Aching _____
 Burning _____ Dull _____ Throbbing _____ Other _____

Have you been treated by another doctor for this problem? _____

If yes, what doctor(s)? _____

What treatment and medication did you receive from them? _____

Did it help? _____

Have you had x-rays for this problem? _____ If yes, when? _____

Where? _____

List any allergies to medicines, chemicals or foods:

Are you on a restricted diet? _____

If yes, explain: _____

Do you use tobacco? _____

If yes, how much? _____

Do you drink alcohol? _____

If yes, how much? _____

Have you taken cortisone in the last year? _____

Have you ever had a fracture? _____

If yes, what and when? _____

Have you had any surgeries? _____

If yes, what kind and when? _____

Name: _____

Date: _____

Check any of the following that you or an immediate family member have ever had:

Condition	You	Family
Lung Problems		
Asthma		
Shortness of Breath		
Tuberculosis		
Anemia		
Bleeding Problems		
Bloody Stools		
Diabetes		
High Blood Pressure		
Colitis		
Stomach Ulcers		
Kidney Problems		
Glaucoma		
Chest Pain		
Heart Attacks		
Brain Surgery or Tumor		
Nervous Problems		
Rheumatic Fever		
Polio		
Neuritis		
Paralysis		
Arthritis		
Other:		

