Thomas Health

**Orthoclinic**
**610 Chestnut Street**
**South Charleston, WV 25309**
**Phone: 304-767-7790**
**Fax: 304-766-7566**

## Patient Information

Patient Name: _____ Social Security #: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Sex: Male Female Date of Birth: _____ Race: _____ Marital State: M S W D

Contact Phone Numbers- Home: _____ Work: _____ Cell: _____

Email Address: _____

Primary Care Physician: _____

Preferred Pharmacy: _____ Address: _____

## Employment Information

Employment Status: _____ Employed _____ Student _____ Retired _____ Unemployed

Employer: _____ Occupation: _____

## Insurance Information

Primary Insurance: _____

Policy Holder: _____ Social Security #: _____

ID #: _____ Policy Holder Date of Birth: _____

Secondary Insurance: _____

Policy Holder: _____ Social Security #: _____

ID #: _____ Policy Holder Date of Birth: _____

***Please provide your Insurance Card and photo ID to the front desk to be copied for our records.***

## Medical Information

Reason For Today's Visit: _____

Date of Injury: _____

How did Injury Occur? _____

If an injury, is the injury: Work Related? Yes No Accident Related? Yes No

Have you ever been treated by another physician for this problem? Yes No

If Yes, please explain (name of doctor and date of treatment):

_____

Have you ever seen another Orthopedist? Yes No Doctors Name: _____

***I agree the information provided today is accurate and up-to-date to the best of my knowledge.***

Signature: _____ Date: _____