Phillip A. Wong, D.O., C.S.P.O.M.M. Osteopathic Manipulative Medicine

3620 Wyoming Blvd., N.E., #128, Albuquerque, NM 87111 (505) 296-8968

PATIENT INFORMATION FORM

Please Print

Name: ______________________ Referred by: ______________________

Address: ______________________

City: __________ State: ____ Zip Code: ________ Phone: ______________

Sex: ________ Marital Status: __________ Birthdate: ____________ Age: ______

Occupation: ______________________ Business Phone: ______________

Employed By: ______________________

Address of Employer: ______________________

Spouse's Name: ______________________ Spouse's Occupation: ______________

Spouse's Employer: ______________________ Business Phone: ______________

Responsible Party (if minor): ______________________

Address: ______________________ Phone: ______________

Friend/Relative not living with you: ______________________

Address: ______________________ Phone: ______________

Medication or Food Allergies or Intolerances *List below medications or foods causing an allergic reaction (i.e., rash, swelling)*			
Medication / Food	***Reaction***	***Medication / Food***	***Reaction***

Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures			
Operation/Hospitalization/Injury	***Mth/Yr***	***Operation/Hospitalization/Injury***	***Mth/Yr***

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Medications, Vitamins and Herbal Supplements					
Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I understand that records are kept for patient care and may not meet insurance company documentation guidelines and coding requirements. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

X ____ Date: ____________________

Signature of Patient (or Guardian)