Background information required for medical insurance submission

For the most efficient billing to your medical insurance provider,
please provide the preferred claim form supplied by your carrier,
which can be obtained from your employer or carrier.

Name_____ Birth date: _____

Address: _____ State:_____ ZIP:_____

Name of the insured person (if above named is a dependant): _____

Insurance ID # (probably the insured SS#) _____ Insurance group :_____

Date of first visit at our office for initial evaluation: _____

How were you referred to our office? _____

1. CHIEF COMPLAINT: (What is it that concerns you most that we can help you with?)

   _____

2. Has an MD diagnosed you as having migraine or tension-type headaches? No Yes when?: _____
3. Physician _____ Phone # _____
4. Were any medications prescribed? No Yes

   If yes, please list: _____
5. Were these treatments successful in relieving your headaches? N Y
6. Do you ever awaken with a headache? No Yes
7. How long can a headache last? _____
8. Where are the headaches usually located? _____
9. What other sensations do you experience associated with your headache/migraine?

   Nausea ____ Light sensitivity_____ Sound sensitivity_____ Must lie down_____

   Other:_____
10. Have you had any other treatment for your headaches? No

    If yes, describe: _____
11. Is there anything else that we should know about your medical or dental history? _____

    _____

    _____