PATIENT INFORMATION
PHILLIP KISSEL, M.D.

Clear

PLEASE PRINT

PATIENT:	
Full Legal Name:	Date of Birth:
Mailing Address:	Male ☐ Female ☐ Age:
City: Zip:	Phone #:
Referred By:	Cell #:
Primary Doctor:	Occupation:
Emergency Contact:	Employer:
Contact Phone #:	Work Phone #:
Pharmacy: City:	Marital Status:

Have you or any family members been treated by Dr. Kissel?	**If yes, Name? Surgery?**

SUBSCRIBER/PARENT OR GUARDIAN:	
Name:	Date of Birth:
Employer:	Work Phone #:
	Cell #:

MEDICAL	**Yes**	**No**		**Yes**	**No**
High Blood Pressure			Seizures		
Heart Disease			Aspirin/Blood Thinning Meds.		
Diabetes			Hepatitis		
Sleep Apnea			HIV		
Prior Radiation Therapy			Cancer		
Mental Health Counseling			Spinal Surgery		

Current Medications	**Allergies or Drug Reactions**	**Major Illnesses and Surgeries**

Work-related injury: _____ Yes _____ No Date of Injury: _____
Personal-related injury: _____ Yes _____ No Date of Injury: _____
Do you have an attorney for this injury: _____ Yes _____ No

As a patient or legal guardian of minor patient, I agree to pay for all services rendered. This office may bill my insurance carrier as needed. "Assignment & Release": I hereby assign my benefits to be paid directly to Phillip Kissel, M.D. I am financially responsible for non-covered services. I authorize the physician to release any information necessary to process this request.

SIGNED: _____ **Date:** _____