CONFIDENTIAL PATIENT INFORMATION

(Please fill out completely)

☐ NEW
☐ UPD

Name (first, last):______________________ Age:________ Birth Date:____/____/______

Address:______________________ City:____________ State:________ Zip Code:__________

Home Phone#:(_____)__________ Mobile Phone#:(_____)__________ Gender: ☐ Male ☐ Female

Social Security #:______________ Does your insurance cover chiropractic care? ☐ Yes ☐ No ☐ Not Sure

Insurance Co.______________ Primary Insured:______________ Policy#:______________

Address:______________________ City:____________ State:________ Zip Code:__________

Major Complaint:____

When did you first notice it?______________ Have you experienced it before? ☐ Yes ☐ No ☐ Sometimes

Does this interfere with your normal living and working? ☐ Yes ☐ No ☐ Sometimes

Was it caused by a fall? ☐ auto accident? ☐ work related incident? ☐ Other?______________

(If you believe this complaint is due to an auto accident or is work related, please fill out back of form completely and sign)

Have you had treatment by another doctor for this? ☐ D.C. ☐ M.D. ☐ Other______________

Name of doctor:______________ Diagnosis:______________

Treatment:______________ Results:______________

What medications are you currently taking?______________

Have you ever suffered from:

Dizziness	☐ Yes ☐ No	Backaches	☐ Yes ☐ No	Heart trouble	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Headaches	☐ Yes ☐ No
Numbness	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Digestive Issues	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	Neuritis	☐ Yes ☐ No

How did you find out about our office?______________

Payment arrangements are expected at time of service:

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that the chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized be paid directly to the chiropractic office and credited to my account on receipt.

However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

______________________ ______________ ______________

Patient Signature Date Date of Birth

______________________ ______________ ______________

Responsible Party/Parent/Guardian Signature Date Date of Birth