Confidential Patient Information

Date: _____

Name: _____ Email: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Age: _____ Date of Birth: _____ Male / Female Married? Yes / No

Children? Yes / No How many? _____

Occupation: _____ Employer: _____

Name of Insurance Company: _____

(Please show insurance card at the front desk if you are covered on this plan)

Following information is only necessary if you are covered by another person's insurance

Subscriber Name: _____

Occupation: _____ Subscriber's Employer: _____

Subscriber's Insurance Company: _____ Subscriber's Date of Birth: _____

(Please show insurance card at the front desk if you are covered on this plan)

Patient's nearest relative & phone number: _____

How were you referred to us? _____

Reason for visit: _____

Please check the boxes that correspond to the symptoms you are experiencing:

☐ low back pain	☐ sciatica	☐ tension	☐ sinus problems
☐ numbness in legs/feet	☐ mid back pain	☐ fatigue	☐ sleeping problems
☐ tingling in legs/feet	☐ knee/ankle pain R/L	☐ irritability	☐ tingling in arms/hands
☐ neck pain	☐ elbow/wrist pain R/L	☐ depression	☐ dizziness
☐ headaches	☐ weakness	☐ shortness of breath	☐ diarrhea
☐ shoulder pain R/L	☐ constipation	☐ buzzing or ringing in ears	☐ numbness in arms/hands

Have you had previous Chiropractic Care? Yes / No By whom? _____

When did your symptoms first appear? _____

Any falls, accidents or injuries (within the past year)? Yes / No Explain: _____

Is this injury work related? Yes / No Date of injury: _____ Explain: _____

Have you ever suffered from:

☐ Anemia	☐ Cancer	☐ Heart Trouble
☐ Arthritis	☐ Diabetes	☐ Sinus Trouble
☐ Asthma	☐ Digestive Disorders	☐ Tuberculosis

Are you taking medication? Yes / No Please list: _____

Have you had any surgeries? Yes / No Please list: _____

Payment is expected at time of visit!

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's staff will submit claims and assist me in collecting from the insurance company. I authorize the insurance company to pay the doctor directly, and that such amounts will be credited to my personal account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I further agree that any credit granted shall be paid promptly in accordance with terms and agreements and that the credit grantor may charge a late fee of $15 per month. In event of default, I agree to pay reasonable collection charges and/or attorney fees.

I authorize the release of any information necessary to process this claim and payment of medical benefits directly to the doctor for services rendered.

Patient's Signature: _____ Date: _____