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PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information is confidential.

Date _____

Name _____ Address _____
City/State/Zip _____ Home phone _____
Social Security # _____ Birthdate _____ Age _____ Male _____ Female _____
Height _____ Weight _____ R or L Handed? _____ Number of Children _____ Married _____ Single _____ Div _____ Widowed _____
Highest level of education completed: 9 10 11 12 College level _____
Occupation _____ Employer _____ Address _____
City/State/Zip _____ Work phone _____
Spouse name (or parent) _____ DOB: _____ Social Security # _____
Occupation _____ Employer _____ Address _____
City/State/Zip _____ Work Phone _____
Patient's nearest relative (not living with you) _____ Phone _____
How were you referred to our office? _____
Have you ever had Chiropractic care before? _____ If so, when? _____
Date of last physical _____ Any serious illnesses? _____
Any operations? _____
Date symptoms appeared or accident happened? _____ Female: are you pregnant? _____

List your chief complaints in order of severity:

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____

List other doctors consulted for these conditions:

1. _____ Address _____
2. _____ Address _____

Is this injury or illness work-related? _____ Have you reported it to your employer? _____
Any days lost from work? _____ Symptoms related to an Auto Accident? _____
Your Auto Ins. Co. _____ Policy # _____ Claim # _____
Name of 3rd. Party _____ 3rd. Party Ins. Co. _____ Claim # _____

Method of payment you plan to use to take care of today's charges:

CHECK _____ CASH _____ MASTERCARD _____ VISA _____ DENCHARGE _____

Medical Insurance _____ Policy # _____ Group # _____
Address _____ City/State/Zip _____

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits payable to me, to be sent directly to the doctor.

Patient Signature _____