WELCOME

ABOUT YOU

Today's Date:_______/_______/________ File #__________
Name:____
Preferred to be called:_________________ ☐ Male ☐ Female
Birthdate:____/____/_____ Age:_____ SS#_____-___-_____
Street Address:_______________________________________
City:______________________State:______Zip:___________
Email:____
Home Phone#: ______________________________________
Cell Phone #: ____
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed
Spouse's Name:_______________________________________
Employer:____
Employer's Address:___________________________________
City:________________________ State:_____ Zip:_________
Occupation:___________________ Phone:_______________
Referred by:____

INSURANCE

Primary Insurance
Insured's Name:________________________________
DOB:_______________ SSN:_____________________
Co. Name:____________________________________
Member ID:___________________________________
Group #:_____________________________________

Secondary Insurance
Insured's Name:________________________________
DOB:_______________ SSN:_____________________
Co. Name:____________________________________
Member ID:___________________________________
Group #:_____________________________________

Medicare
Insured's Name:________________________________
DOB:_______________ SSN:_____________________
Medicare ID:__________________________________

Medigap Policy
Insured's Name:________________________________
DOB:_______________ SSN:_____________________
Co. Name:____________________________________
Member ID:___________________________________
Group #:_____________________________________

REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ☐ Yes ☐ No
If so, please explain: ____
____

The reason of this visit is a result of (Please circle): work / sports / auto / trauma / chronic
Please explain:____
____
____

Please describe the pain and its location: ____
____

When did the condition begin? ______/______/________
Is this condition getting worse? ☐ Yes ☐ No ☐Constant ☐ Comes and goes
Is this condition interfering with your (please circle): work / sleep / daily routine
If so, please explain: ____
____

Have you had this or similar conditions in the past? ☐ Yes ☐ No
If so, please explain: ____
____

Have you been treated by a Medical Physician for this condition? ☐ Yes ☐ No
If so, where? ____

IN EVENT OF EMERGENCY

Who should we contact?_______________________________

Relation:____

Home phone: ____

Cell phone:____

Work phone:____

ACCOUNT INFO EMERGENCY

Person ultimately responsible for account

Name:____

Relation:_______________________________________

Billing Address:__________________________________

City:_________________ State:______ Zip:_________

SSN:____

Driver's License #:________________________________

Phone: __________________ Cell:__________________

HEALTH HISTORY

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killers(including aspirin) ☐ Muscle relaxers ☐ Stimulants ☐ Blood thinners ☐ Tranquilizers ☐Insulin ☐Other___________________

Have you ever had any of the following diseases / medical conditions?

Y / N Heart Attack/Stroke	Y / N Heart surg./Pacemaker	Y / N Heart Murmur
Y / N Congenital Heart Defect	Y / N Mitrial Valve Prolapse	Y / N Artificial Valves
Y / N Alcohol / Drug Abuse	Y / N Venerial Disease	Y / N Hepatitis
Y / N HIV + / Aids	Y / N Shingles	Y / N Cancer
Y / N Frequent Neck Pain	Y / N Empysema / Glaucoma	Y / N Anemia
Y / N High/Low Blood Pressure	Y / N Psychiatric Problems	Y / N Rheumatic Fever
Y / N Severe/Frequent Headaches	Y / N Kidney Problems	Y / N Ulcers / Colitis
Y / N Fainting/Seizures/Epilepsy	Y / N Sinus Problems	Y / N Asthma
Y / N Diabetes / Tuberculosis	Y / N Difficulty Breathing	Y / N Chemotherapy
Y / N Lower Back Problems	Y / N Artificial bones / Joints	Y / N Arthritis

Please list any other serious medical condition(s) you have or have ever had: __________________________________
____

Please list anything to which you may be allergic:____
____

List previous surgeries / treatments with dates:____
____

List any **past** serious accidents with dates:____
____

Do you smoke? ☐ No ☐ Yes / how much?__________________ How long?___________

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports

What is the age of your mattress?______ Is it comfortable? ☐ Yes ☐ No

For women: Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ No ☐ Yes/How long?____ Are you nursing? ☐ Yes ☐ No

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited to my 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. If it is necessary to send unpaid fees to collections, all fees incurred, including all attorney fees and interest will be the responsibility of the patient.

I will be paying today by ____ Cash ____ Check ____Credit Card ____ Care Credit

Patient's Signature ____ Date: ______________________