1one

Welcome

ABOUT YOU

Today's Date: _____ File #:_____

Patient Name: _____
Last First MI

What do you prefer to be called? _____ _Male _Female
Birth date: ___/___/____ Age: ____ SS#: _____
Mailing address: _____

_____
City State Zip

Home phone: _____
Work phone: _____
Cell phone: _____
E-mail address: _____
Referred By: _____
Employer: _____
Employer's address: _____

_____
City State Zip

Occupation:_____
Status:_Minor _Single _Married _Divorced _Separated _Widowed
Spouse's name: _____
Do you have children? __Yes __ No How many? ___

2two

INSURANCE INFO

Co. Name: _____
Address: _____

_____
City State Zip

Phone #:_____
Insured's SS#:_____
Group #:_____
Insured's Name: _____
Relation: _____
Insured's DOB:____/____/_____
Insured's Employer: _____

_____

Please inform front desk of 2nd insurance source

3three

REASON FOR VISIT

The reason for this visit is a result of (*Please Circle*):work, sports, auto, trauma, or chronic
(Explain what happened): _____

_____
Please describe the pain & it's location: _____

_____
When did condition begin? ____/_____/_____
Is this condition getting worse?__Yes __No __Constant __Comes and goes
Is this condition interfering with your (*Please Circle*): work, sleep, or daily routine
If so, please explain: _____
Have you ever had this or similar conditions in the past? ___Yes ___No
If s, please explain: _____
Have you ever been treated by a Medical Physician for this condition?
___Yes ___No
If so, where? _____
Have you ever been treated by a chiropractor before? __Yes __ No
If so, whom? _____ Phone #:_____

four

IN EVENT OF EMERGENCY

Who should we contact?_____
Relation: _____
Home phone #: _____Work #_____
Who is your medical doctor? _____ Phone #:_____

five

HEALTH HISTORY

Are you taking any of the following medications?

☐Nerve pills ☐Pain killers (including aspirin) ☐ Muscle relaxers ☐ Stimulants

☐Blood Thinners ☐ Tranquilizers ☐ Insulin ☐Other (s) _____

Do you have or ever had any of the following diseases or conditions?

Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart murmur
Y N Congenital Heart Defect	Y N Mirtal Valve Prolapse	Y N Artificial Valves
Y N Alcohol/Drug Abuse	Y N Venereal Dusease	Y N Hepatitis
Y N HIV+/Aids	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/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/had:

_____

Please list anything that you may be allergic to: _____

_____

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

_____

Family Health History: _____

_____

Do you: Take Supplements or Vitamins? ☐Yes ☐No / Exercise? __
Are you on a special diet: ☐ Yes ☐ No / Since: _____/____/_____
Do you smoke? ☐ Yes ☐ No / How Much? _____ How long? ___
What is the age of your mattress? ____ Is it comfortable? ☐Yes ☐No
Are you wearing ☐Heel lifts ☐Sole lifts ☐Inner Soles ☐ Arch Support
For women: Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ No ☐ Yes/How long? ___Nursing? ☐ Yes ☐ No

six

ACCOUNT INFO

Person ultimately responsible for account

Name: _____
Relation: _____
Billing Address: _____

_____
SSN: _____
D.L.# _____
Work Phone: _____
Payment Method:
☐Cash ☐ Check ☐ Credit

_____
Credit Card-Enter card # above

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance co. (I offered at this office)

- We invite you to discuss with us any questions regarding our services. The best health based on a friendly, mutual understanding between provider and patient.
- Our policy requires payments in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days if the date if service and no financial arrangements have been made, you will responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date____/____/_____