# CHIROPRACTIC ASSOCIATES 4444 MAIN STREET BRIDGEPORT, CT 06606

NAME_____ HOME PHONE_____
First Last

ADDRESS_____APT # _____CITY_____STATE_____ZIP_____

S.S.#_____CELL#_____E-MAIL_____

BIRTHDATE_____AGE_____ MALE/FEMALE MARITAL STATUS:_____ #OF CHILDREN_____

EMPLOYED BY_____OCCUPATION_____WORK#_____

EMPLOYER'S ADDRESS_____CITY_____ZIP_____

SPOUSE'S NAME_____SPOUSE'S EMPLOYER_____

SPOUSE'S S.S.#_____

**HOW DID YOU HEAR ABOUT OUR OFFICE?** _____

DOCTOR PREFERRED TODAY?_____

YOUR FAMILY PHYSICIAN_____

OTHER DOCTORS SEEN FOR THIS CONDITION_____

IS YOUR INJURY DUE TO AN ACCIDENT/INCIDENT? **YES / NO**

DESCRIPTION OF ACCIDENT/INCIDENT:_____

DO YOU HAVE HEALTH INSURANCE? **YES/NO** NAME OF THE INSURANCE_____

POLICY #_____ NAME OF ANY OTHER HEALTH INSURANCE_____

**HAVE YOU EVER SUFFERED FROM:**

1) DIZZINESS_____
2) BACKACHES_____
3) HEART TROUBLE_____
4) DIABETES_____
5) TUBERCULOSIS_____
6) ALLERGIES____
7) ARTHRITIS_____
8) HEADACHES____
9) ASTHMA_____
10) NEURITIS_____
11) NERVOUSNESS____
12) PREGNANCY____
13) SINUS TROUBLE____
14) ANEMIA_____
15) RHEUMATIC FEVER____
16) CANCER_____
17) FAMILY HISTORY OF CANCER_____
18) STROKE _____

**LIST ANY SURGICAL OPERATIONS AND YEARS:** _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND CARPENTER CHIROPRACTIC ASSOCIATES WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY. ANY AMOUNT PAID DIRECTLY TO CARPENTER CHIROPRACTIC ASSOCIATES WILL BE CREDITED TO MY ACCOUNT UPON RECEIPT. I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. IN THE EVENT OF DEFAULT, THE UNDERSIGNED AGREES TO PAY ALL REASONABLE COSTS OF COLLECTION, INCLUDING COURT COSTS, COLLECTION FEES AND REASONABLE ATTORNEY'S FEES.

PATIENT'S SIGNATURE:_____DATE _____

PARENT/GUARDIAN'S SIGNATURE_____DATE _____

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EMPLOYER'S ADDRESS_____CITY_____ZIP_____

SPOUSE'S NAME_____SPOUSE'S EMPLOYER_____

SPOUSE'S S.S.#_____

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**LIST ANY SURGICAL OPERATIONS AND YEARS:** _____

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