Welcome

ABOUT YOU

Today's Date:_____File #:_____

Name:_____

What you Prefer To Be Called:_____☐ Male☐ Female

Birth date:____/____/____Age:_____SS#:_____

Home Address:_____

_____
City State Zip

Home Phone#:_____

Cell Phone#:_____

Work Phone#:_____

Referred By:_____

Employer:_____How Long?_____

Employer's Address:_____

_____
City State Zip

Occupation:_____Work Phone #:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name:_____

Email:_____

INSURANCE INFO

Company Name:_____

Address:_____

Phone #:_____

Insured's SS# :_____

Group # (Plan, Local or Policy #):_____

Primary care Physician:_____

_____
City State Zip

Insured's Name:_____

Relation:_____Date of Birth____/____/____

Insured's Employer:_____

Please inform front desk of 2nd Insurance source.

IN EVENT OF EMERGENCY

Who should we contact?_____

Relation:_____

Home Phone #:_____

Work Phone #:_____

REASON FOR VISIT

Have you ever been treated by a chiropractor before? ☐Yes ☐No

If so, please explain:_____

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 you *(Please Circle):* work, sleep, or 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?_____

- We invite you to discuss with us any questions regarding our services. The best health services are base on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no finacial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider 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 in my medical status.

Signature_____Date_____