CONFIDENTIAL PATIENT INFORMATION

The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, please ask the receptionist.

Date _____

Were you referred to a certain doctor at this Clinic? If so, who? _____

Referred by (check one, please):

☐ Patient ☐ Family ☐ Phone book ☐ Sign
☐ TV ☐ Mail ☐ Web site ☐ Other
_____

Is your visit due to an accident? ☐ Yes ☐ No Work Phone: (____) _____

Is your visit due to a work-related injury? ☐ Yes ☐ No

PATIENT DATA

Name _____ Driver's License No. _____

Home Phone: (____) _____ E-Mail address_____

Address _____ City _____ State _____ Zip _____

Age_____ Birthdate _____ Marital Status _____

Number of Children _____ Occupation _____

Employed by _____ SS# _____

Employer address _____ Phone (____) _____

Name of nearest relative _____ Phone (____) _____

Name of spouse _____ SS# _____

Occupation of Spouse _____ Employer _____

Employer address _____ Phone(____) _____

PRESENT COMPLAINT
Briefly describe symptoms
_____
_____
_____

List other doctors seen for this condition
_____

Are you presently seeking an attorney for this injury or illness?
_____

CONSENT TO TREAT A MINOR
I hereby authorize the Chiropractic Health Center to administer chiropractic care as deemed necessary to my child:

_____
_____
Witness
Signature
Date _____
Date _____

MEDICAL HISTORY

If any of the following are relevant to your medical history or any family member's medical history, please check boxes accordingly.

☐ Cancer	☐ Muscular Dystrophy	☐ Rheumatic fever
☐ Polio	☐ Multiple Sclerosis	☐ Scarlet fever
☐ Tuberculosis	☐ Convulsions	☐ Nervousness
☐ High Blood Pressure	☐ Epilepsy	☐ Asthma
☐ Heart Trouble	☐ Concussion	☐ Digestive Disorders
☐ Diabetes	☐ Dizziness	☐ Sinus Trouble
☐ Hepatitis	☐ Arthritis	☐ Backaches
☐ German Measles	☐ Neuritis	☐ Numbness

□ Venereal Disease □ Rheumatism □ Anemia

Describe the operations you've had:
_____
_____
_____

When and Where?
_____

Have you been treated by a physician for any health condition in the last year?
□ Yes □ No Describe condition:_____
_____ Date of last physical exam: _____

Are you allergic to any medication? □ Yes □ No What kind?
_____

Are you taking any medication? □ Yes □ No What kind?
_____

Are you pregnant? □ Yes □ No Date of last menstral period:
_____

INSURANCE DATA: (Clinic policy requires payment arrangements be made on the first visit.)

Name of party responsible for payment:
_____

Do you have insurance? □ Yes □ No Company
_____

Please list all sources of insurance:

Patient's Insurance: _____ Employee I.D. No.
_____

Spouse's Insurance: _____ Policy No.
_____

Worker's Compensation: _____ Group No.
_____

Others: _____ Medicare No.
_____

X-RAY CONSENT AGREEMENT:

I, _____, do hereby give my consent to Chiropractic Health Center and its representatives to take x-rays as deemed appropriate by the examining Doctor of Chiropractic. I also hereby declare that I am not pregnant.

_____

Signature