Confidential Patient Information

Date _____

Name _____ Home Phone _____
Address _____ Zip Code _____
Cellular Phone _____ E-mail _____
Age _____ Birth Date _____ Marital Status: M S W D How many Children? _____
Occupation _____ Employer _____
Address _____ Office Phone _____
Insurance Company _____ Agents Name _____
Policy # _____ Social Security No _____
Name of Spouse _____ Occupation _____
Employer _____ Office Phone _____
Patient's Nearest Relative _____
Address _____
Referred by _____
Date of last Examination _____

Have you ever suffered from:	Yes	No		Yes	No
1. Dizziness	☐	☐	8. Asthma	☐	☐
2. Backaches	☐	☐	9. Neuritis	☐	☐
3. Heart Trouble	☐	☐	10. Digestive disorders	☐	☐
4. Diabetes	☐	☐	11. Nervousness	☐	☐
5. Tuberculosis	☐	☐	12. Sinus Trouble	☐	☐
6. Arthritis	☐	☐	13. Anemia	☐	☐
7. Headaches	☐	☐	14. Cancer	☐	☐

Purpose of this appointment _____
Other Doctors seen for this condition _____
Have you been treated for any health condition by a physician in the last year? ☐ YES ☐ NO
Describe _____
Remarks and additional information _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT!
Name of person responsible for payment _____
Are you insured? ☐ YES ☐ NO Company _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Nunez Chiropractic, P.S.C. will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount I authorized to be paid directly to Nunez Chiropractic, P. S.C. 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.

Patient's Signature: _____ Date _____
Guardian or Spouse's Signature: _____ Date _____
Information Taken By: _____ Date _____