Confidential Patient Information

Date _____ Phone/Cell # _____

Name _____ Preferred Name: _____ Sex _____ Marital Status _____ D.O.B. _____
First and Last Names M/ F/NB S/M/D/W Area Code/Number Mo/Day/Yr

Address _____ City _____ State _____ Zip Code _____

Race: ☐ American Indian ☐ Alaska Native ☐ Asian ☐ African American ☐ Hawaiian Native ☐ Other Pacific Islander ☐ Caucasian

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Language Spoken_____

_____
Social Security # **Occupation** **Company Name** **Location** **Work Phone Number**

_____
Guardian/Spouse's Full Name **Guardian/Spouse's D.O.B.** **Guardian/Spouse's Employer** **Work Phone Number**

Email Address:_____

Name of nearest relative (not your spouse): _____ Phone: _____

Who referred you to our office? _____Were you referred to a certain doctor?_____

Is your visit due to an accident? ____ No ____ Yes (if yes, please see the receptionist for an injury report)

YOUR PRESENT COMPLAINT _____

BRIEFLY DESCRIBE YOUR SYMPTOMS _____

List other doctor(s) seen for this condition:_____

Personal Medical History (if any of the following are relevant to your medical history, please check the accompanying box:)

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

Describe any operations you've had and the dates: _____

_____

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 now taking any medication? ☐ Yes ☐ No What kind? _____

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

Are you pregnant? ☐ Yes ☐ No Date of last menstrual cycle: _____

Do you have insurance? ☐ Yes ☐ No Company _____

I.D. No. _____ Policy Group No. _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection form the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charges directly to me and that I am personally responsible for payment. It is my understanding that my credit may be checked if Waldo Chiropractic Group extends credit to me and 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 unless prior arrangements are made. I hereby authorize the doctors at Waldo Chiropractic Group and whomever they may designate as their assistants to administer treatment as they so deem necessary and I also authorize the release of any information acquired in the course of my examination or treatment. I certify that the above is true and correct.

Patient's (Parent or Guardian's) Signature _____