Welcome to SOUTHPORT CHIROPRACTIC

1995 Post Road
Fairfield, CT 06824
203-259-1555

Date _____

Confidential Patient Information

Name _____ Social Security Number_____

Street Address_____City_____State_____Zip_____

Cell Phone_____Home Phone_____Birth Date_____

Email Address_____ Cell phone carrier _____

Marital Status: Married/Single/Widowed/Divorced Number of Children_____

Occupation_____Employer_____

Employer Address _____Employer Phone _____

Emergency Contact _____Relationship to patient _____

Emergency Phone Number_____

I was referred to SOUTHPORT CHIROPRACTIC by _____

Purpose of this appointment _____

Primary Physician _____Phone Number _____

Physician Address/City _____

Have you seen any other doctors for this condition? _____

Have you been treated by any health providers in the last year? ☐ yes ☐ no

Describe _____

Have you ever suffered from any of the following? (check all that apply)

☐ Dizziness/Vertigo	☐ Headaches/Migraines	☐ Digestive Disorders
☐ Neck Pain	☐ Heart Trouble	☐ Nervousness
☐ Back Pain	☐ Diabetes	☐ Sinus Trouble
☐ Arthritis	☐ Cancer	☐ Anemia
☐ Neuritis	☐ Asthma	☐ Numbness/Tingling
☐ Other _____	☐ Other _____	☐ Other _____

Does patient have health insurance? ☐ yes ☐ no

Family Health Profile

Please review the conditions listed below and indicate those that are ***current*** health problems of a family member by writing ***"C"*** under his/her column. Please write ***"P"*** to indicate a problem that has occurred in the past. Leave blank the spaces that do not apply.

CONDITION	Father Age___	Mother Age___	Spouse Age___	Brothers Age___	Age___	Sisters Age___	Age___	Children Age___	Age___	Age___
Allergies/Sinus Trouble										
Arthritis/Rheumatoid										
Asthma										
Back Trouble										
Cancer										
Constipation										
Diabetes										
Digestive Trouble										
Disc/Nerve Problems										
Fatigue										
Headaches/Migraines										
Heart Trouble										
High/Low Blood Pressure										
Kidney Trouble										
Liver Trouble										
Reproductive Issues										
Neck/Shoulder Pain										
Scoliosis										
Seizures										
Sleep Distubances										
TMJ/Jaw Pain										
Weight Issues										
Other:										

I understand and agree that I am personally responsible for paying for all services rendered to me by Southport Chiropractic. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore I understand that Southport Chiropractic will prepare any necessary reports and forms to assist me in collecting from my insurance company, and that any amount authorized to be paid directly to Southport Chiropractic will be credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any outstanding fees for services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature _____ Date _____

Payment required at time of visit