PATIENT INFORMATION

Welcome to our office! Please complete all questions. Thank you!

Name:_____Date:_____

Address:_____City/State/Zip:_____

Home Phone:_____Work Phone:_____

Cell Phone: _____Email:_____

Birth Date:_____Age:_____Social Security #:_____

Marital Status: M W D S Driver's License #:_____State:_____

Your Employer:_____Occupation:_____

Employer's Address: _____Phone #:_____

Spouse's Name:_____Spouse's Employer:_____

Do you have health insurance?_____Name of Company:_____

Insured's Name:_____Date of Birth:_____SS#:_____

Children's Names and Ages:_____

Favorite Hobbies or Interests:_____

Please list 3 goals you have (these can be professional, personal, or spiritual):

1._____

2._____

3._____

Who may we thank for referring you to our office?_____

Method of payment for first visit: _____Cash _____Check _____Credit Card _____Gift

Current Health complaints:

1._____

2._____

3._____

Have you had same or similar problem(s) before:_____

If so, for how long?_____

Is this the result of an auto or work injury?_____If so, when?_____

(OVER)

Father, mother, brother, sister, children with similar problem?_____

Have you ever been to a Chiropractor before? YES or NO If yes, when?_____

_____

Other Doctors you have seen for this problem:_____

Surgeries you have had:_____

Medications you are currently taking:_____

Is there any chance you are pregnant?_____

Have you ever been diagnosed with cancer?_____If so, what kind?_____

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's signature_____Date_____

Guardian's Signature Authorizing Care_____Date_____