PATIENT HISTORY & EXAMINATION

NAME_____ CELL PHONE ( )_____ HOME PHONE ( )_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HT._____ WT._____ AGE _____ BIRTHDATE_____ MARITAL STATUS: M S W D NO. CHILDREN_____

SOCIAL SECURITY #_____ DRIVERS LICENSE #_____

BEST WAY TO CONFIRM YOUR NEXT APPOINTMENT ☐ CELL ☐ HOME

E-MAIL ADDRESS_____USED BY OUR OFFICE ONLY !

OCCUPATION_____ EMPLOYED BY_____ PHONE ( )_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

REFERRED BY_____

_____

PREVIOUS TREATMENT FOR THIS CONDITON:

_____ DC _____ MD OTHER_____ NAME_____

RESULTS_____

HAVE YOU BEEN PLACED ON DISABILITY? _____ BY WHOM? _____

_____

FAMILY PHYSICIAN_____ TELEPHONE ( )_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

NEAREST RELATIVE (Not living with you)_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

TELEPHONE ( )_____ RELATIONSHIP_____

PAYMENT ARRANGEMENTS ARE EXPECTED BEFORE SERVICES ARE RENDERED:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Chiropractic Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

PATIENT'S SIGNATURE_____ DATE_____