Confidential Patient Information

INSTRUCTIONS: Please Print

Name: ____ SSN#: ______________________
Last First M.

Street Address: ____ Apt #:_________

Mailing Address: __________________________________ (if different)

City:___________________ St:___ Zip:_______ Driver’s Lic#___________________

(HM)#:(___)____________________ (WK)#:(___)_______________ Ext#:____________

(Cell)#:(___)________________ Email:____

Birth Date: _______________ Age: __________ Marital Status: S M D W

Occupation: ______________________ Employed by: ____________________________

Spouse's Name: ___________________ Employed by: ____________________________

Spouse's SSN: ________________________ DOB: ______________________________

Referred by: (Friend/Relative) (Internet/Web Site) (Yellow Pages)

Referring Physician: _______________________ Other: ________________________

Which one of our patients may we thank for referring you?:_________________

PLEASE INDICATE CONDITIONS:

a) Headaches	b) Upper back pain	c) Knee pain	d) Stomach
e) Neck pain	f) Midback pain	g) Ankle pain	h) Chest pain
i) Neck stiffness	j) Lowback pain	k) Foot pain	l) Numbness
m) Shoulder pain	n) Hip pain	o) Sinus	p) Arthritis
q) Arm pain	r) Tailbone	s) Asthma	t) Sciatica
u) Wrist pain	v) Leg pain	w) Allergies	x) Nervousness
y) Dizziness	z) Blurred vision	aa) Sleeplessness	bb) Tremors

Other Complaints?:____

My condition is due to?: (Please circle)

Auto Accident; Work Accident; Home Accident; Other:________________________

HAVE YOU EVER HAD SPINAL SURGERY? (NO) (YES) If yes, please explain:________

List all other surgeries: ____

Previous Chiropractor: ____________________________ Were you satisfied?: Y N

Medical Dr:___________________________ Attorney:___________________________

Please circle the medications you are taking:

Birth Control	Muscle Relaxers	Tranquilizers
Blood Pressure	Pain Killers	Vitamins
Heart Medication	Sleeping Pills	Other:_____________________

FEMALES ONLY: ARE YOU PREGNANT AT THIS TIME? (NO) (YES)

I UNDERSTAND THAT FULL PAYMENT FOR SERVICES RENDERED IS DUE AT THE END OF EACH VISIT.

My account will be settled by:

a)Cash/Check/Charge b)Group Insurance c)Spouse's Insurance

Primary Insurance Company:____

Address:____

Phone#:(___)__________ Group#:___________ Policy#:__________________________

Guarantor ’s Information if different from patient:

Name:____ DOB:__________________________

Address:____

Phone#:(___)_____________ Employer:____

Secondary Insurance Company (Spouse's Ins.):________________________________

Address:____

Spouse's S.S.#:_______________________ Date of Birth:_______________________

Phone#:(___)__________ Group#:___________ Policy#:__________________________

Signature:____ Date:________________