# Patient Information

**Date** _____ Patient #_____
**Doctor** _____

Name _____ Social Security # _____ Home Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birth Date _____ Cell _____ Marital: M S W D How many children? _____

Occupation _____ Employer _____

Employer's Address _____ Office Phone _____

Spouse _____ Occupation _____ Employer _____

Name of Nearest Relative _____ Address _____ Phone _____

How were you referred to our office? _____

Purpose of this appointment _____
Date symptoms appeared or accident happened _____
Have you ever had the same or a similar condition? • Yes • No If yes, when and describe: _____

_____

Days lost from work _____
Date of last physical examination _____ What surgeries have you had? (Include dates) _____

_____

Serious illnesses (include dates) _____

_____

Have you been treated for any health condition by a physician in the last year? • Yes • No
If yes, describe: _____

_____

What medications or drugs are you taking? _____

_____

Please check any and all insurance coverage that may be applicable in this case.

- Major Medical
- Worker's Compensation
- Medicaid
- Medicare
- Auto Accident
- Other

Name of Primary Insurance Company

Name of Secondary Insurance Company (if any)

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 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. I understand that interest is charged on overdue accounts at the annual rate of 16%.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____