

Please Fill This Out Completely

Please Print

Date: _____

Name _____

Address _____ Apt. # _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____

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

Occupation _____ Employer _____

Address _____ Work phone _____

Name of Spouse _____ Employer _____

Family Physician _____ Date of physical examination _____

Referred by _____ Your e-mail: _____

Have you ever suffered from:

- | | |
|------------------------|------------------------------|
| 1. Dizziness _____ | 9. Asthma _____ |
| 2. Backaches _____ | 10. Neuritis _____ |
| 3. Heart Trouble _____ | 11. Digestive Disorder _____ |
| 4. Diabetes _____ | 12. Nervousness _____ |
| 5. Tuberculosis _____ | 13. Sinus Trouble _____ |
| 6. Arthritis _____ | 14. Anemia _____ |
| 7. Headaches _____ | 15. Stroke _____ |
| 8. HIV _____ | 16. Cancer _____ |

Purpose of this appointment _____

Other doctors seen for this condition _____

Have you been treated for any health conditions by a physician in the last year? ()yes ()no

Describe: _____

Remarks and additional information _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment _____

Are you insured? ()yes ()no Company _____

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 Center 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 Center 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.

Patients Signature _____ Date _____

Social Security # _____