

PATIENT INFORMATION:**DATE:**

Name: _____ Home: () _____ Cell: () _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security No. _____ Marital Status: S/M/D _____ Date of Birth: ___/___/___

Driver's license # _____ Occupation: _____

Employer: _____

Work Phone: () _____ E-mail address: _____

Name of spouse or nearest relative: _____ Phone # () _____

How did you learn about us? Yellow pages ___ (book name _____) Spanish Yellow pages ___ Newspaper ___

Web ___ Tele-marketing ___ Sign ___ Insurance company ___ Other: _____ Referred by: _____

Please check type of care desired: () Lasting Correction () Temporary Relief

What is your major problem?	#1	#2	#3
Describe your pain (sharp, dull, numb, burn, throb, sore, shooting, tingling, weak).			
How long have you had this?			
How did it happen?			
How does this affect your life?			
Does the pain radiate? Travel? Where?			
When do you notice the pain the most?			

Please list any past or present: () hospitalization () injuries

PLEASE EXPLAIN:

() illnesses () allergies () medications

Has anyone in your family had: () arthritis () blood problems

() cancer () diabetes () genetic disorders

What do you do at work? _____ # of hours/week _____

List hobbies/sports: _____

I order my insurance company to pay directly to this chiropractic office and authorize the doctor to treat myself and or children as needed. I authorize the doctor to release records or request records as needed. I understand that I am directly responsible for any changes including deductibles and co-pays. I also understand that this office does not offer to diagnose or treat any disease or condition other than vertebral subluxations (misalignments).

Signature: _____

Date: _____

FOR OFFICE USE ONLY**(Make copy of insurance card)****Dr. Name** _____

Insurance Co. _____ Adjuster _____ Phone # _____

Bills sent to: _____

Name of insured _____ Policy still in effect: Y/N _____ Date effective: _____

Policy # _____ Group # _____ Chiro: Y/N _____ % X-Rays: Y/N _____ %

Massage: Y/N _____ PT: Y/N Limit: _____ Supports / Vitamins: Y/N _____

Deductible: Y/N \$ _____ Amt. Met: \$ _____ Co-Pay: \$ _____

Max # of TX: _____ Max Ins. Pay: \$ _____ # Visits used/ amt used: _____

Referral from PCP? Y/N _____ Name of PCP _____

Authorizations needed? Y/N _____ # TX approved: _____ Time period covered: _____

Special instructions: _____

Verified by: _____