

# WELCOME

ABOUT YOU

1  
one

Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long? \_\_\_\_\_

Occupation: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Widowed \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Children: # \_\_\_\_\_ Ages: \_\_\_\_\_

Previous Chiropractor: \_\_\_\_\_ Current Primary Physician: \_\_\_\_\_

Please, we need to photocopy your insurance card(s).

Insurance Company Name: \_\_\_\_\_

Claims address: \_\_\_\_\_  
\_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy holders Group # \_\_\_\_\_

Policy holder's SS#: \_\_\_\_\_

Policy holders name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy holder's Employer: \_\_\_\_\_

Please Inform front desk of any second insurance source.

tWO

INSURANCE INFO

# IN EVENT OF AN EMERGENCY

Who should we contact: \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

# three

## Are you taking any of the following medications?

- |   |   |  |                                     |
|---|---|--|-------------------------------------|
| <input type="checkbox"/> Nerve Pills    | <input type="checkbox"/> Pain Killers (including aspirin) | <input type="checkbox"/> Muscle Relaxers | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Tranquilizers                    | <input type="checkbox"/> Insulin         |                                     |
| <input type="checkbox"/> Other(s) _____ |   |  |                                     |

## Have you ever had any of the following diseases/medical conditions?

- |                               |                                |                        |                             |
|-------------------------------|--------------------------------|------------------------|-----------------------------|
| Y N Heart Attack/Stroke       | Y N Heart Surg./Pacemaker      | Y N Heart Murmur       | Y N Congenital Heart Defect |
| Y N Mitral Valve Prolapse     | Y N Artificial Valves          | Y N Alcohol/Drug Abuse | Y N Venereal Disease        |
| Y N Hepatitis                 | Y N HIV+/AIDS                  | Y N Shingles           | Y N Cancer                  |
| Y N Frequent Neck Pain        | Y N Emphysema/Glaucoma         | Y N Anemia             | Y N Kidney Problems         |
| Y N High/Low Blood Pressure   | Y N Psychiatric Problems       | Y N Rheumatic Fever    | Y N Ulcers/colitis          |
| Y N Severe/Frequent Headaches | Y N Fainting/Seizures/Epilepsy | Y N Sinus Problems     | Y N Asthma                  |
| Y N Diabetes/Tuberculosis     | Y N Difficulty Breathing       | Y N Chemotherapy       | Y N Lower Back Problems     |
| Y N Artificial Bones/Joints   | Y N Arthritis                  |                        |                             |

Please List any other serious medical Condition(s) you have or ever had: \_\_\_\_\_

Please List any hospitalizations or surgeries: \_\_\_\_\_

List any past serious accidents with dates: \_\_\_\_\_

Do you Smoke?  No  Yes/How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Are you wearing:  Heel Lifts  Sole Lifts  Inner Soles  Arch Supports

What is the age of your mattress? \_\_\_\_\_ Is it comfortable?  Yes  No

Are you pregnant?  No  Yes/How Long? \_\_\_\_\_  Nursing?  Yes  No

# four

HEALTH HISTORY

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PATIENT

Name \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# five

## ACCOUNT INFO