



New Patient Form
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PATIENT INFORMATION

Patient Name: _____ DOB: _____
Prefer to be called: _____ Male / Female Minor / Single / Married / Divorced / Widowed
Address: _____ SSN: _____
City: _____ State: _____ Zip: _____
Home Ph#: (_____) _____ Cell Ph#: (_____) _____
Medical Doctor: _____ Ph#: (_____) _____

EMPLOYER INFORMATION

Employer Name: _____ Supervisor: _____
Address: _____
City: _____ State: _____ Zip: _____
Insurance: _____
Adjuster Name: _____ Ph#: (_____) _____

HEALTH INSURANCE INFORMATION

Insurance Co: _____ Policy #: _____
Address: _____ Group #: _____
City: _____ State: _____ Zip: _____
Ph#: (_____) _____

Insured's Name: _____ DOB: _____
Relationship: _____

_____: I authorize assignment of my insurance rights and benefits to the provider for services rendered. I
(initial) understand that I am solely responsible for balance not paid by my insurance company.

Insured's Employer: _____
Insured's Employer Address: _____
City: _____ State: _____ Zip: _____

IN EVENT OF AN EMERGENCY

Contact Name: _____ Relationship: _____
Home Ph#: (_____) _____ Cell Ph#: (_____) _____

Our office policy requires payment at the time services are rendered, unless other arrangements are made. The patient is responsible for legal/collection agency fees, as well as interest charges or other expenses if the balance remains unpaid past 90 days of the last treatment. The staff and provider are authorized to perform necessary services during diagnosis and treatment, and to release the information needed to process claims through insurance.

By signing below, I acknowledge that I have received a copy of the Summary of Privacy Notice. I also understand the information stated above. The information provided is the most current and accurate to my knowledge. It is my responsibility to update this office of any changes.

Signature: _____ Date: _____

Patient Name: _____ Date: _____

REASON FOR VISIT

Reason for today's visit: Emergency New injury Chronic Pain Wellness

Are you in pain? _____ If yes, rate your pain: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Is this injury the result of: Auto Accident Work Routine/Household activity Play/Sports

When did the accident/injury happen? ____/____/____ Where did your injury occur? _____

Explain what happened in your own words: _____

Is your condition: Getting worse Constant Comes and goes

Is your condition interfering with your: Work Sleep Routine

If so, how? _____

PLEASE CIRCLE THE AREAS YOU ARE HAVING TROUBLE WITH ON THE DIAGRAM >>

Has a similar incident ever happened before?

If so, please explain: _____

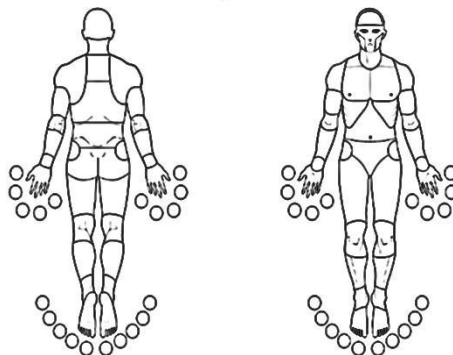
Have you been treated by a medical physician for this condition?

Yes No Where?: _____

Have you ever been treated by a Chiropractor?

Yes No Clinic Name: _____

Ph#: (_____) _____



HEALTH HISTORY

Are you taking any of the following medications?

Nerve pills Pain killers Muscle relaxers Blood thinners Tranquilizers Insulin Other _____

Do you have or have you had any of the following diseases, medical conditions of procedures? Please circle

- | | | |
|-------------------------|----------------------------|----------------------------------|
| Heart attack/stroke | Fainting/seizures/epilepsy | Glaucoma |
| Artificial valves | Chemotherapy | Sever/frequent headaches |
| Shingles | Heart murmur | Emphysema/asthma |
| High/low blood pressure | Vereal disease | Artificial bones/joints/implants |
| Ulcers/colitis | Frequent neck pain | Mitral valve prolapse |
| Difficulty breathing | Rheumatic fever | HIV+/AIDS/ARC |
| Heart surg./pacemaker | Sinus problems | Anemia/Diabetes |
| Alcohol/drug abuse | Lower back problems | Kidney problems |
| Cancer | Congenital heart defect | Tuberculosis |
| Psychiatric problems | Hepatitis | Arthritis |

List Surgeries with dates: _____

Allergies: _____

Family Health History: _____

Do you take supplements/vitamins: _____

Do you smoke? _____

Do you exercise? _____

Are you pregnant? _____ Wks: _____