

Patient Information Form

First Name _____ M.I. _____ Last Name _____ Sex Male Female

Birthdate ____ / ____ / ____ Age _____ Marital Status (S M W D) Spouse's Name _____

Social Security # _____ Home Phone (____) _____ Work Phone (____) _____

E-Mail Address _____ Cell Phone (____) _____

Address _____ City _____ State _____ Zip _____

Driver's License No. _____ State _____

Employer _____ Job Title _____

Work Address _____ City _____ State _____ Zip _____

Person Responsible For This Account _____

In Case Of Emergency Notify _____ Phone _____

Primary Insurance: Policy # _____

Insurance Co. _____ Group # _____

Name of Insured _____ Relationship to Patient _____ SS # _____

FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition.

To keep our office overhead down and keep our patient fees reasonable, we expect payment at the conclusion of each treatment.

To familiarize you with the financial policy of our office, I would like to explain how your medical bills will be handled.

Payment Arrangements:

It is our policy in this office to maintain your account on a current basis.

Charges for treatment are due at the time the service is provided.

I understand that I am personally responsible for my co-pay / co-insurance and any non-covered services rendered.

I understand that I will be charged \$25.00 fee if I do not cancel my appointment in advance of the time it is scheduled.

Voluntary Termination of Care:

It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

If, at any time, you have any questions about your care, please do not hesitate to ask.

Patient's Signature _____ Date _____

What is your major complaint: _____

1) Is this condition due to an: Auto accident Work Injury Other accident Unknown cause Illness

2) Are symptoms: Improving Getting worse About the same Intermittent (come and go)

Date symptoms appeared: _____

3) Activities that aggravate your condition:

Standing Walking Sitting Lying Bending Lifting Twisting Coughing

4) Have you had these symptoms before: Yes No If so, when? _____

5) Have you seen another doctor for this condition: M.D. Chiropractor Date consulted _____

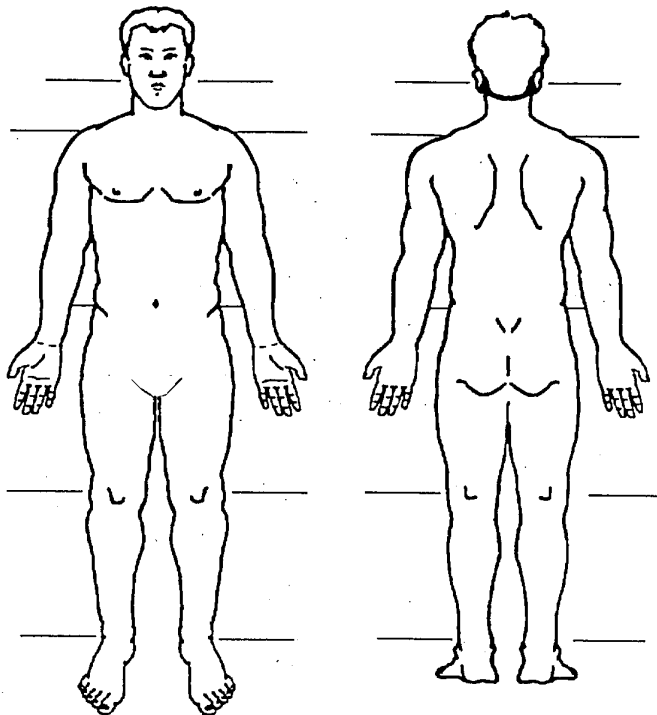
Doctors name _____

CHECK SYMPTOMS YOU ARE EXPERIENCING:

- Dizziness
- Ringing in ears
- Nausea
- Indigestion
- Poor Appetite
- Diarrhea
- Constipation
- Vomiting
- Fainting
- Loss of balance
- Loss of sleep
- Nervousness
- Depression
- Weight Loss
- Weight Gain
- Difficulty Focusing
- Difficulty concentrating
- Heart Palpitations
- Fatigue
- Irritability
- Allergies
- Menstrual Irregularity
- Light bothers eyes
- Fever
- Frequent or painful urination
- Cramps

Please Indicate The Following Areas:

B – Burning D – Dull Ache S – Sharp/Stabbing
N – Numbness T – Tingling P – Pins & Needles



GRADE LEVEL OF PAIN
 FROM 1 TO 10
 0= None 10= Severe

HEADACHES	
NECK PAIN	
SHOULDER PAIN (Right or Left)	
ARM PAIN (Right or Left)	
CHEST PAIN	
LOW BACK PAIN (Right or Left)	
HIP PAIN (Right or Left)	
LEG PAIN (Right or Left)	
OTHER (Right or Left)	